DOCUMENT RESUME

ED 272 597 UD 024 743

TITLE	A Guide for Developing Non-Instructional Programs.
INSTITUTION	National Urban League, Inc., New York, N.Y.
SPONS AGENCY	Department of Education, Washington, DC.
PUB DATE	Dec 83
CONTRACT	300-80-0861
NOTE	238p.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC10 Plus Postage.
DESCRIPTORS	*Agency Cooperation; *Ancillary School Services; Cooperative Programs; Elementary Secondary Education; Health Programs; Needs Assessment; *Program Design; *Program Development; Program Evaluation; *Program Implementation; Psychological Services; School Role; Social Services
IDENTIFIERS	Follow Through Services NY

ABSTRACT

This handbook presents a comprehensive, step-by-step guide for educators, parents, and community leaders who are interested in providing non-instructional services in an educational setting. The general concepts are based on a program development model that has been adapted to the special concerns of non-instructional in-school programs. The specific ideas and examples in the handbook are derived from the experiences of Follow Through Program sites in New York City, which included health services, social services, guidance and psychological services, and nutrition services. The main body of the handbook consists of five sections which outline program development: (1) Needs Assessment (identifying the problems and needs to be addressed by the program); (2) Program Design (planning service delivery and management strategies for addressing these needs); (3) Program Implementation (operating the program based on clearly specified program objectives); (4) Program Monitoring (determining whether the program is being implemented efficiently and effectively and is meeting its service delivery and management objectives); and (5) Interagency Cooperation (forming linkages with other agencies and programs for the sharing and exchanging of ideas and resources). The handbook also presents a case study of non-instructional services in the Follow Through Project, a workbook containing worksheets and a checklist for each stage of program development, and an extensive annotated bibliography. Charts, tables, and other illustrative material are included to provide a capsule view of the program development process and to present examples of the concepts and activities being discussed. (KH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED272597

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

C. Gibson
Nat'l Urban League, N.Y.

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

A GUIDE FOR DEVELOPING NON-INSTRUCTIONAL PROGRAMS

DECEMBER 1983

National Urban League, Inc.
Career Training and Economic Resources Department
Education and Career Development Cluster
500 East 62nd Street
New York, New York 10021

This guide was developed in fulfillment of Contract #NEW 300-80-0861 between the U.S. Department of Education and the National Urban League, Inc. The opinions or points of view expressed in this document do not necessarily reflect the position or policy of the U.S. Department of Education.

UD 024743

ADVISORY PANEL

- Ms. Terry Clark
- Ms. Ruth Flurry
- Dr. Edmond Gordon
- Mrs. Helen Green
- Mrs. Hattie Hunt
- Mrs. Hortense Jones
- Ms. Marjorie McAllister
- Dr. Eugene Ramp

CONSULTANTS

- Ms. Elinor Bowles
- Dr. Kay Clanton
- Ms. Gloria Dandridge
- Dr. Anderson J. Franklin
- Mr. Harold Freeman
- Ms. Rosalind Hammond
- Ms. Susan Koen
- Dr. Marilyn Musumeci
- Dr. Greg McQuater
- Dr. Bernadette Nelson
- Dr. Edwardo Rhodes
- Dr. William Taylor

STAFF

Walter W. Stafford, Ph.d.
Project Director

Juanita P. Mendez
Research Coordinator

Catherine Lyons
Field Coordinator

Jean Marie Borden
Program Coordinator

Edwin P. Dei
Research Associate

Stephan Dixon
Special Assistant

Erslyn L. Brown
Administrative Secretary

Maribel Vasquez
Clerk-Typist

CONTENTS

Page

Acknowledgements 1

The Handbook 3

Introduction 5

SECTION I: NEEDS ASSESSMENT 13

Purpose and Rationale 14

The Needs Assessment Process 16

Step A. Initiate the Needs Assessment Process 16

Step B. Determine What Information Is Needed 20

Step C. Determine the Sources of Information 23

Step D. Collect the Information 26

Step E. Analyze, Data, Determine Priorities, and Prepare Report 31

SECTION II: PROGRAM DESIGN 37

Purpose and Rationale 38

The Program Design Process 39

Step A. Initiate the Program Design Process 39

Step B. Review Community Organizational Factors 41

Step C. Clarify the Program's Mission: Philosophy, Conceptual Basis, and Global Goals 43

Step D. Explore Service Options and Select Specific Services to Be Delivered 45

Step E. Prepare the Service Delivery Plan 51

Step F. Prepare the Management Plan 55

Step G. Design the Monitoring System 70

SECTION III: PROGRAM IMPLEMENTATION 73

Purpose and Rationale 74

The Program Implementation Process 76

Step A. Refine the Program Design 76

Step B. Hire Staff 78

Step C. Prepare Physical Facilities 81

Step D. Prepare Materials 82

Page

Step E. Consolidate Interagency Linkages 83

Step F. Conduct Orientation and Pre-Operational Meetings 84

Step G. Train Staff to Implement Monitoring System 84

Step H. Develop Inservice Training Program 84

Step I. Begin On-going Operation 85

SECTION IV: PROGRAM MONITORING 89

Purpose and Rationale 90

The Monitoring Process 91

Step A. Develop the Monitoring Plan 91

Step B. Implement the Monitoring Plan 97

Step C. Report Findings 98

Step D. Incorporate Findings into the Program Design 99

SECTION V: INTERAGENCY COOPERATION 105

Purpose and Rationale 106

Interagency Cooperation Process 108

Step A. Identify and Describe Community Agencies 108

Step B. Define Interagency Linkages 112

Step C. Implement and Maintain Interagency Linkages 116

Step D. Monitor Interagency Linkages 116

A Case Study: Establishing and Maintaining a School-Based Comprehensive Non-Instructional Services Program 121

Workbook: Non-Instructional Program Development

Annotated Bibliography

ACKNOWLEDGEMENTS

The collective efforts of a large number of individuals have gone into the formation of this handbook. The project staff would like first to acknowledge the staff in various units of the National Urban League who contributed administrative support and technical assistance. Special recognition is owed to Ms. Carol Gibson, Director of Education.

We would also like to express gratitude to the Follow Through staff of the New York City Board of Education and to the staff and parents of the Follow Through sites for selfishlessly sharing their time to help us understand the development of non-instructional services in Follow Through. The handbook is based on the archival and anecdotal information they provided. We are particularly grateful to Lois Knox for assisting us in obtaining information from Follow Through archival records and for critiquing portions of the handbook.

We are especially indebted to our Advisory Panel for their professional guidance during the developmental phases of the project. The completion of the handbook was accomplished with the invaluable expertise and skills of our consultants. We would like to note especially the assistance of Harold Freeman, who worked with us from the inception of the project to its completion, and Elinor Bowles, who was responsible for the final organization and editing of the handbook. Finally, we express our gratitude for the enormous assistance rendered by Stephan Dixon in formating and typing this handbook.

THE HANDBOOK

This handbook contains a comprehensive, step-by-step guide for educators, parents, and community leaders who are interested in providing non-instructional services in an educational setting. The general concepts are based on a program development model. The specific ideas and examples in the handbook are derived from the experiences of Follow Through Program sites in New York City. The information that is presented should be of value for any school interested in establishing or expanding a program of non-instructional services.

The guidelines are based on a program development model that has been adapted to the special concerns of non-instructional in-school programs. The core of the handbook consists of five sections that together offer a roadmap for non-instructional program development:

Needs Assessment: Identifying the problems and needs to be addressed by the program.

Program Design: Planning service delivery and management strategies for addressing these needs.

Program Implementation: Operating the program based on clearly specified program objectives.

Program Monitoring: Determining whether the program is being implemented efficiently and effectively and is meeting its service delivery and management objectives.

Interagency Cooperation: Forming linkages with other agencies and programs for the sharing and exchange of ideas and resources.

In addition to the above sections, the handbook contains a case study of non-instructional services in the New York City Follow Through Project, a workbook containing worksheets and a checklist for each stage of program development, and an annotated bibliography. Charts, tables, and other illustrative material are included to provide a capsule view of the program development process and to present examples of the concepts and activities being discussed.

We realize that each non-instructional program is unique. The constellations of needs to be addressed will be unique for each particular community. The resources that are available, particularly budgetary factors, will differ. The combination of needs and resources will determine the degree to which each step in the program development process can be implemented and the kinds of services that can be provided. Consequently, the guidelines contained here are intended primarily to indicate the range of factors to be considered in initiating or redesigning a non-instructional program and do not constitute a blueprint that must be followed in exact detail.

An attempt has been made to make the guidelines comprehensive without overwhelming the reader with unnecessary detial. Conversely, it was recognized that the handbook could not cover every situation or contingency that might occur. Our goal, therefore, was to find a reasonable balance between generality and specificity. We hope that readers, by using these guidelines as a framework and a point of departure, will find them useful in developing non-instructional programs tailored to their particular schools and communities--their specific needs and goals and the resources that are available.

Throughout the country, Follow Through programs have met the challenge of providing non-instructional services for low-income children. This handbook is an effort to make their experiences available for all those who are interested in developing similar services.

8

INTRODUCTION

I THE PROJECT: BACKGROUND & METHODOLOGY

In October 1981, the U.S. Department of Education awarded a contract to the National Urban League to prepare guidelines based upon the process that had been used by Follow Through projects to develop non-instructional services. This effort marked the first time this process had been systematically studied and interpreted for practical use by a larger audience.

Under the leadership of the New York City Board of Education, the six Follow Through sites used as the basis for this handbook have emerged as among the most successful in the nation. They present a rich storehouse of data and experience. First, they provide each of the non-instructional components outlined in the Federal guidelines (see Table 1, on page 6). Second, the records of the program are readily accessible. Third, many of the parents, teachers, coordinators, nurses, and other staff have either remained in the program or were still in New York City at the time of the study and available for interviews. Finally, a consistent strand in the development of Follow Through in New York City has been a high degree of cooperation between the Board of Education, project sites, project sponsors, municipal agencies, and community organizations. This proved an enormous asset for the National Urban League project staff, since the most essential requirement for developing comprehensive non-instructional services is intra-agency and interagency cooperation.

This handbook was prepared after the completion of a year's research. During this period, the following activities were conducted: an extensive

Table 1

Follow Through Non-Instructional Components*

Health	Responds to both short- and long-range needs by providing (1) screening, referrals, and corrective treatment for all low-income Follow Through children (2) preventive activities such as health education for Follow Through children and their families and (3) activities designed to encourage and improve related community health services.
Social Services	Aids families of low-income Follow Through children in identifying and solving family problems, and assists in the development of more effective community social services for low-income families.
Guidance and Psychological Services	Uses trained psychological personnel to assist the psychological development of low-income Follow Through children through (1) classroom observations followed by consultation with teachers, teacher aids, and other staff members; (2) staff development of pertinent Follow Through personnel; (3) work with Follow Through parents; and (4) testing and appropriate follow-up for Follow Through children where necessary
Nutrition	Provides for (1) daily type A lunch (USDA recommended), (2) breakfast and snacks where necessary, (3) nutrition education and counseling for Follow Through children and their parents, and (4) training in nutrition for Follow Through staff members.

*The non-instructional components listed above are the focus of this handbook. Other non-instructional components mandated by Follow Through include parent and community involvement, orientation and training, career development, and adult education opportunities.

review of the literature related to non-instructional in-school services; a consensus conference of Follow Through administrators, sponsors, coordinators, parents, and National Urban League staff; interviews with Federal officials, Follow Through staff, and parents; and direct observation of the operation of Follow Through sites.

II FOLLOW THROUGH

Follow Through, which was established in 1967 under an amendment to the Economic Opportunity Act of 1964, was designed to maintain the progress made by children in Head Start and similar preschool programs. As in Head Start, a central feature of the Follow Through Program is the emphasis on the total child as well as his or her family and community. The program is based on the conviction that children from low-income families require more than traditional classroom instruction if they are to have improved life chances. Because of this basic premise, the decision was made to provide a range of services that would address the full spectrum of young children's non-instructional needs, as spelled out in Table 1.

Three goals of Follow Through are to:

- Provide innovative instructional programs.
- Provide for the direct involvement of the parents of the children enrolled in the program.
- Provide non-instructional services to meet the total needs of the child: medical, dental, nutritional, psychological, and social.

Innovative Instructional Programs

Between 1967 and 1971, four regional educational laboratories and eighteen universities and colleges that had developed innovative, experimental approaches to the education of young children were invited to participate as sponsors in the national Follow Through Program. School systems with large numbers of low achieving low-income children also were selected to participate and were given the option of choosing one of the innovative educational approaches or developing their own.

Parent Involvement

A central component of all Follow Through project sites is direct parent participation in all aspects of the program in order to (1) support and influence the program, (2) contribute more fully to the child's total development, and (3) help translate the needs and goals of the parents and community into meaningful project activities.

At least four major kinds of parent activities are necessary for an effective Follow Through project:

- Participation in decision-making about the nature and operation of the project through a Policy Advisory Committee.
- Direct participation in classroom, school, and project activities as paid employees, volunteers, or observers.
- Regular contacts between home and school.
- Parent education and community activities that parents have helped develop.

The Policy Advisory Committee (PAC) is the primary mechanism for achieving parent involvement and must play a substantial role in the planning and management of the Follow Through project. The PAC, therefore, should be involved in all phases of the program development process, from needs assessment through monitoring. Some of its responsibilities are to:

1. Help develop and approve project applications.

12

2. Assist in the development of criteria for selection of project staff and review criteria prior to implementation.
3. Assist in the recruitment and hiring of project staff.
4. Assist in the development of procedures for selecting eligible children for the project and assure that such procedures are followed.
5. Assess the effectiveness of the project and make recommendations for improvement to the project coordinator and/or other appropriate personnel.
6. Help to plan and organize educational and social activities for Follow Through parents.
7. Mobilize community resources and secure the active participation of Follow Through parents in the project.
8. Keep all Follow Through parents informed of ongoing and new project activities as well as important decisions to be made.

In turn, each project should provide the PAC with information on:

1. The structure and organization of the school system
2. Selection and recruitment standards for school personnel
3. The budget
4. The decision-making process in the project
5. The purpose and history of all school programs that affect Follow Through
6. All regulations, guidelines, and policies that are applicable to Follow Through
7. All evaluations of the project
8. Planning processes that the grantee may be undertaking and that may affect Follow Through
9. General data concerning the needs of children enrolled in Follow Through

Parent involvement is crucial to the success of any non-instructional program and should be an active influence in each stage of the program development process.

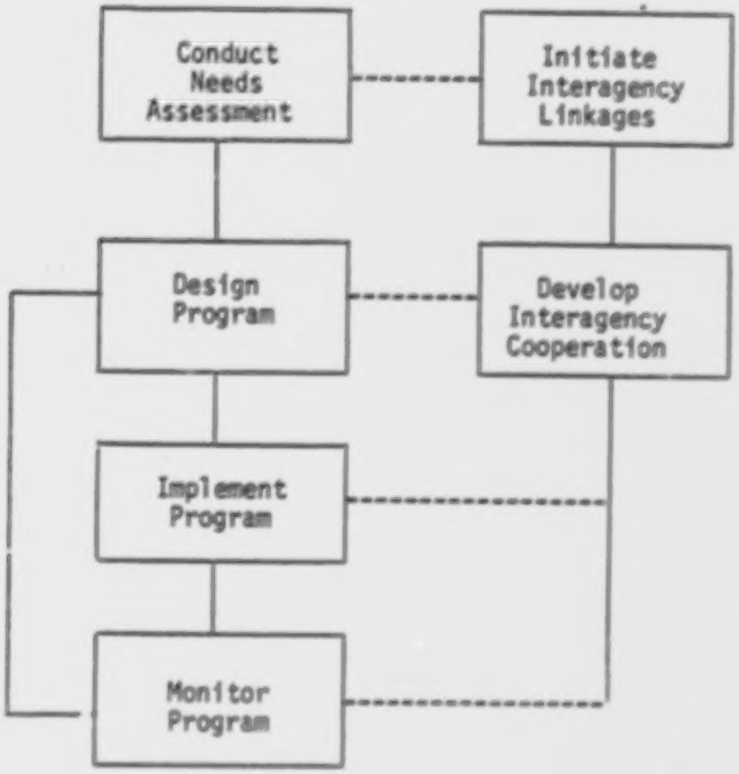
Non-Instructional Services

Non-Instructional Services in Follow Through, which were patterned after Head Start, were developed in recognition of the impact of multiple forces on the child's academic achievement and life chances. A basic tenent of both Head Start and Follow Through, therefore, is that if children are to achieve academically, their physical, emotional, and social needs must also be attended to. Consequently, the following goals were established:

- to improve the child's physical health and abilities
- to foster the emotional and social development of the child
- to strengthen positive family relationships
- to provide constructive opportunities for social institutions to work together with the poor in solving their problems

To accomplish these goals, it was designated that the following services be provided: medical, dental, nutritional, social and psychological. It was also considered necessary that these programs establish viable working relationships with other community agencies.

PROGRAM DEVELOPMENT
NON-INSTRUCTIONAL SERVICES


Conduct Needs Assessment
Initiate Interagency Linkages
Design Program
Develop Interagency Cooperation
Implement Program
Monitor Program

NEEDS ASSESSMENT

NEEDS ASSESSMENT

A systematic process of collecting and analyzing data in order to identify the problems and needs to be addressed by the program.

KEY FACTORS TO BE CONSIDERED

- Who should be included in the design and execution of the needs assessment process?
- How much time is available to conduct the needs assessment?
- What is the scope of the needs assessment and what resources are available to conduct it?
- What information is needed and where can it be obtained?
- How will the information be collected and analyzed?
- After a variety of needs have been identified, how will the specific needs to be addressed by the program be determined?

PURPOSE & RATIONALE

The first requirement for developing a program of non-instructional services is to recognize the vast array of problems that can impede academic development. For example, inadequate health care, poor nutrition, child abuse, domestic violence, and overcrowded housing are just a few of the many problems that can have a negative effect on the education of young children.

The second requirement is to decide which of these problems the program should focus on. The needs assessment process will help make these decisions.

The needs assessment process has four basic functions:

1. To identify specific non-instructional problems that interfere with the educational development of children in the community.
2. To identify and to assess existing community and school services.
3. To determine what additional services are needed.
4. To decide which of these needs should be addressed by the non-instructional program.

The needs assessment process provides the foundation on which the non-instructional program will be built. Despite its importance, however, it is often not given adequate time or attention. Sometimes program planners assume that they already know what the community's problems and needs are. To some extent, this may be true when people are familiar with their community. However, a thorough needs assessment can provide additional information to substantiate impressions, document the extent of problems, reveal problems or needs that are hidden beneath the surface, and pinpoint some of the reasons for the problems.

The needs assessment process described in this guide is intended for use prior to the design and implementation of the program. However, needs assessment is an ongoing process that continues throughout the life of the program. During program implementation and monitoring, needs assessment techniques are used to help determine what new services should be added to the program, which services should be eliminated, and which services should be redesigned.

Depending on its purpose and the resources available for its execution, the needs assessment processs can range from quite simple to very complex. For any needs assessment, however, careful planning its required.

THE NEEDS ASSESSMENT PROCESS

The five major steps in the needs assessment process are:

A. Initiate the Needs Assessment Process
B. Determine What Information Is Needed
C. Determine the Sources of Information
D. Collect the Information
E. Analyze Data, Determine Priorities, and Prepare Report

STEP A. INITIATE THE NEEDS ASSESSMENT PROCESS

A-1. Assemble a Needs Assessment Team

The Needs Assessment Team is a working group that will be responsible for planning, overseeing, and perhaps executing the needs assessment process. The team should be manageable in size, usually not more than six people. It should include persons who will have responsibility for designing and implementing the program as well as persons who will be recipients of services.

The basic criteria used for selecting members of the Needs Assessment Team include:

- Familiarity with the target population
- Familiarity with the community's institutions and resources
- Familiarity with the organizational context in which the non-instructional program will operate (e.g., a single school, a group of schools, an entire school system)

Since needs assessment is essentially a research undertaking--data gathering and analysis--team members should include at least one person familiar with survey research methods. In addition, the members should be individuals who work well in a group, are task oriented, are capable of making objective decisions, and have a strong commitment to non-instructional programs. Categories of persons who should be considered for membership include:

- Parents
- School Administrators/Principals
- Teachers
- Representatives of Community Agencies
- Community Leaders and Decision Makers
- Faculty of Local Colleges

Where possible the Needs Assessment Team should include persons who also will be involved in program design and implementation. It is particularly important that school representatives, preferably the principal if possible, be included in program development from the inception so that their views can be represented in the decision-making.

A-2. Outline the Major Tasks of the Needs Assessment Team

The tasks that are part of the assessment process include:

- Determining the purpose and scope of the needs assessment
- Identifying who will carry out the tasks of the needs assessment
- Identifying key community agencies, organizations, and groups
- Reviewing prior community studies or related needs assessments
- Determining what information must be collected
- Selecting sources of information
- Determining data collection methods and preparing data collection instruments
- Collecting data
- Analyzing the data
- Preparing the needs assessment report

In addition to the above, three important responsibilities of the Needs Assessment Team are to (a) keep the program's Policy Advisory Committee informed about the progress of the needs assessment, (b) initiate communication with relevant community organizations and groups in order to develop community support for the program even before it begins, and (c) provide a bridge between needs assessment and program design in order to assure continuity in the program development process. These tasks should be coordinated by a team leader, whose responsibility is to oversee the entire needs assessment process.

Many of the tasks to be performed during the needs assessment (and throughout the program development process) will require group decision-making. There are various techniques for group decision-making, most of which have certain commonalities. These are some basic guidelines:

1. Clearly define the topic to be discussed.
2. Provide group members with time to think quitely about the topic and to consider their responses. Depending on the complexity of the topic under consideration, this may take from 5 to 15 miniutes.
3. Ask each group member to give his or her response(s). In some cases, members may be asked to write their responses and then read them to the group.
4. Record responses on newsprint or blackboard.
5. After all responses have been presented, discuss each idea individually.
6. After all ideas have been discussed, take a group vote on each idea.

This process will permit all group members to voice their opinions and to enter into focused, directed discussion.

A-3. Determine the Scope of the Needs Assessment

The scope of the needs assessment will be determined by how extensive the program is intended to be. As described in the introduction, a comprehensive non-instructional program for children and parents consists of five basic components: medical, dental, nutrition, psychological, and social. The scope of the needs assessment can be broad and include an examination of all these areas. After the data have been analyzed, the Needs Assessment Team may decide to focus on one or on all of the components. On the other hand, the needs assessment can be narrowly defined and examine only one area, such as medical care. Or it may examine several areas, such as medical, dental, and nutritional needs.

The scope of the needs assessment will be a determining factor in establishing a time period, the data to be collected, sources of data, data collection methods, and the types of resources that are required.

A-4. Establish a Time Frame

The amount of time allocated for the needs assessment will be related to factors such as (a) the scope of the needs assessment, (b) the amount of time available, (c) the expertise of the persons involved, and (d) the mandates of the funding agency and/or the sponsoring organization. Generally, four to six weeks is sufficient time to conduct a needs assessment. After the amount of time has been determined, a schedule should be made for the accomplishment of the tasks outlined in A-2.

A-5. Identify Who Will Carry Out the Tasks of the Needs Assessment

Depending on the complexity of the needs assessment, the skills represented on the Needs Assessment Team, the resources available, and other factors, the members of the team may or may not perform the actual tasks necessary to carry out the needs assessment process. Persons with research and writing skills may be hired to carry out the actual work. Paid or voluntary consultants may be needed if there is a large amount of data to be collected, organized, and analyzed. Such efforts will likely require computer services and persons familiar with statistical analysis. In some instances it may be possible to arrange for a local college to design and conduct your needs assessment as one of its community service projects. In any case, the Needs Assessment Team will be responsible for determining the purpose of the needs assessment, determining who will carry out the tasks, and planning and overseeing the project.

STEP B. DETERMINE WHAT INFORMATION IS NEEDED

The information to be collected is determined by the scope of the assessment and the resources (i.e., personnel, budget, and time) available for conducting it. Team members should pinpoint the critical issues to be studied and the information that is necessary to illuminate them. Two types of information should be collected: quantitative (for example, the percentage of children in the target population who have not received dental services in the past two years) and qualitative (for example, the reasons why children do not receive regular dental care). A review of prior community studies and needs assessments will help determine what information you must collect.

The information that is collected should be specific enough to reveal the extent of the problems, influencing factors, community resources that are available, and insight about possible solutions. The information should not be so detailed and complex, however, that the assessment process becomes burdensome or beyond the resources or expertise available. And it should be expected that some information that is collected will not be used for this initial needs assessment. However, it probably will serve as a valuable data base for future studies. Also, some important information will probably not be easily obtainable. Information from hospital records, income data, and client data from private and public social agencies, for example, are often

Table I-1

Types of Information

1. Demographic, Social, and Economic Data
    - a. Profile of adult population in target group by race, ethnicity, sex, and income
    - b. Number of children in target group by age, race, ethnicity, and sex
    - c. Percentage of families in target group receiving some form of public assistance, e.g., Aid to Dependent Children, Food Stamps, Medicaid, Social Security Benefits
2. Status of Children and Families

    Types and extent of problems identified by families, health service providers, and teachers
3. Services Currently Being Received by Children and Families
    - a. Frequency of visits to doctors, dentists, etc.
    - b. Extent of involvement with psychological and social services
    - c. Types of providers used, e.g., clinics, private practitioners, hospital emergency rooms
4. Profile of Key Agencies and Institutions in the Community
    - a. Public agencies
    - b. Private agencies
    - c. Religious institutions
5. Description of Relevant Services Provided in the Community
    - a. Medical services
    - b. Dental services
    - c. Nutritional services
    - d. Psychological services
    - e. Social services
    - f. Miscellaneous (e.g., recreation, adult education, training)

(Table I-1 Continued)

6. Interagency Coordination

   a. Methods used to ensure interagency cooperation and coordination (e.g., interagency task forces, coalitions, federations, conferences, newsletters)
   b. Centralized recordkeeping systems and information that is available
   c. Agencies that handle information and referral for the types of problems to be addressed by the non-instructional program
   d. Systems among agencies for sharing information about specific clients
   e. Gaps in services and service coordination

7. Cultural Factors

   If the program is to be successful, it is important to understand the values and attitudes of the children and their parents as well as the larger community. This can be obtained best through sensitive observation and a day-to-day familiarity with the target population. Some data that might be gathered are:

   a. Extent of church involvement
   b. Family composition patterns, e.g., single parent families, extended families
   c. Amount of social organizations, e.g., the number and kind of fraternal, social, and civic organizations
   d. Willingness of parents to interact with and to accept non-instructional services from your sponsoring organization

8. The Community's Physical Environment

   a. Housing conditions: types of housing (e.g., apartments, private dwellings), condition of housing, density, vacancy rate, housing costs
   b. Urban or rural features
   c. Number and types of industries and businesses
   d. Public transportation: availability and cost

difficult to secure. And the cost of obtaining certain types of census data is generally prohibitive. This usually will not affect the quality of the study if the material that is gathered focuses on the critical issues. (The group decision-making process that has been described in Step A-2 will be useful in helping the Team select critical issues to be studied.)

Table I-1, on page 21, provides a comprehensive list of types of information that are of value for a non-instructional program. The determination as to specific information that should be collected for a given program must be made by each Needs Assessment Team.

STEP C. DETERMINE THE SOURCES OF INFORMATION

Numerous sources of information exist in every community. General sources and the types of information they provide are listed below. While it probably will not be necessary to survey each data source during the needs assessment, they all should be identified for possible later use. The decision as to which specific sources to survey will depend on the assessment's purpose and scope and the resources available for collecting and analyzing the information.

Table I-2

Sources of Information

1. Medical and Social Service Providers in the Community
    a. major problems existing in the community
    b. services being provided in the community
    c. gaps in services
    d. demands for services
    e. capacity to respond to human service problems
    f. pattern and extent of interagency cooperation
    g. agency profiles

(Table I-2 Continued)

2. Federations of Medical and/or Social Agencies
    a. statistical information regarding families and children, including percentages of families receiving some form of public assistance
    b. pattern and extent of interagency cooperation
3. City Planning Departments
    a. income and other economic data by census tracts
    b. housing characteristics
    c. descriptive information about community
4. Health Departments
    a. community health data
    b. prevalence rates for certain diseases
5. Mental Health Associations
    a. psychological problems, rate and prevalence in community
    b. service gaps
    c. services being provided in community
6. Comprehensive Health Planning Agencies
    a. health data regarding medically underserved populations
    b. demands for services
    c. services provided
    d. gaps in services
7. Universities
    a. community studies and needs assessments
    b. indices of social and family disorganization
    c. consultation
8. Census Bureau
    a. income and other economic data by census tracts

(Table I-2 Continued)

9. Religious Institutions
    - a. cultural traditions
    - b. service needs

10. Families in Target Population
    - a. profile of target population
    - b. self-perceived problems and service needs of target population
    - c. services currently being received

11. Sponsoring Organization and Schools
    - a. major problems existing in the community
    - b. profile of target population
    - c. absenteeism rates and causes

12. Community Leaders
    - a. major problems existing in the community
    - b. cultural traditions
    - c. services being provided in the community

13. Prior Community Studies and Needs Assessments
    - a. various types of statistical data
    - b. descriptions of problems and needs

When contacting agencies for information, it should be made clear that the purpose of the study is not to evaluate agency performance but to identify problems, service needs, and resources that can help in the development of the non-instructional program.

In most of the sources, information can be obtained from documents or from key individuals. Some important types of documents and categories of individuals are listed on the following page.

Documents

Community Studies or Needs Assessments. In almost every community there are studies that provide an analysis of children, families, services, and problems. These often can be obtained from community organizations, colleges and universities, and government agencies. Although these studies usually will provide only partial information related to the purpose of your needs assessment, they can be valuable not only for the data they contain but as a guide in designing your own needs assessment.

School Records. Absenteeism rates and reasons for absences, which can be found in school records, are important baseline data for non-instructional programs, since a major goal is to increase attendance.

Reports from Medical and Social Service Agencies. The annual as well as special reports from these agencies can provide important data for agency profiles, type and extent of problems, services provided, and barriers to service utilization.

Key Individuals

The people who can provide information include service providers, community leaders, community activists, children and their families, teachers, school administrators. People are a particularly rich source of information about the community's cultural traditions. When deciding which people to contact, it is useful to know the type of information they are likely to have and the possible advantages and disadvantages of using them as a data source. Table I-3, on page 27, outlines this information.

STEP D. COLLECT THE INFORMATION

D-1. *Choose Information Gathering Methods*

The actual collection of information can take many forms. Information gathering methods and their advantages and disadvantages are outlined in Table I-4, on page 29.

Table I-3

Sources of Information: Individuals

Categories	Types of Information	Possible Advantages	Possible Disadvantages
Service Providers			
Administrative and program staff of community agencies	existing and potential community resources problems or service needs which might not be widely recognized degree to which various services are utilized barriers to service utilization	assessment based on professional judgment assessment based on actual experience develops interagency cooperation and linkages	information may be limited to specific agency problems and needs identified may reflect biases or vested interests of providers data may reflect only needs of those being served and not those who are currently unserved
Community Leaders			
Representatives of various constituencies e.g., clergy, elected officials, and other spokespersons	problems which can become public issues and receive widespread exposure issues of importance to vocal and active segments of community	provides overview of community problems indicates problems likely to be opposed or supported by community leaders can provide varied perspectives to community problems develops community cooperation and linkages	may be limited in scope may reflect specific bias, e.g., religious or political may alienate some leaders who are not included

Table I-3 (Cont'd.)

Sources of Information: Individuals

Categories	Types of Information	Possible Advantages	Possible Disadvantages
Community Activists			
Leaders in social, fraternal, and civic organizations	attitudes of the community cultural factors history of community	can provide a personal perspective can provide insights into values and behavior can provide anecdotal data	may not perceive interrelationships among problems
Intended Recipients of Services			
Children and their families	profile of specific children and their families	identifies self-perceived problems and needs involves intended recipients in program at an early stage of program development provides more detailed information than might be available from other sources	may lack a broad-based perspective

Table I-4

Information Gathering Methods: Advantages and Disadvantages

Method	Advantages	Disadvantages
Review of Documents	provides quantitative data that is easy to code, tabulate, and categorize provides factual information inexpensive	access may be difficult may be outdated information may not be well organized
Mailed Questionnaires	can survey a large number of respondents can be completed at respondent's leisure relatively easy to tabulate information respondent can be annymous	long time for information to be received may get low response or entail much follow up questionnaire must be well written in order to be self-explanatory readability must be commensurate with level of respondents' reading skill
In-person Structured Interviews (with questionnaires)	personal contact can probe for appropriate answers and clarify meaning of questions additional information can be gained from observation of person and surroundings	can be expensive due to amount of training required for interviews and amount of time required to collect data lack of anonymity
In-person Unstructured Interviews (without questionnaires)	(see "structured interviews".) gives more freedom than structured interviews to explore areas of interest to respondent easier to explore attitudes, feelings, etc., than in structured interviews	(see "structured interviews".) sometimes difficult to keep respondent on the subject requires a great deal of skill on the part of the interviewer

(Table I-4 Continued)

Method	Advantages	Disadvantages
Telephone Interviews (structured or unstructured)	personal contact faster and less expensive than in-person interviews	less relaxed that in-person interviews; more difficult to establish rapport interviewer must judge respondent's attitude without benefit of visual clues
Group Meetings	allow for exchange of ideas can stimulate the generation or creation of ideas time-saving and cost-effective	can turn into a debate or a forum for a particular point of view require a very skilled group discussion leader to ensure full participation and to cover all issues

D-2. Prepare Data Collection Instruments

After the information gathering methods to be used have been determined, data collection instruments must be prepared. These should be concise, easy to understand, and in a format that will simplify data collection, tabulation, and analysis. Individual instruments may be required for different sources of information, depending on the particular information that is desired. Some questions, however, will be relevant to all sources.

You may be able to obtain some of the instruments, or models that can be used, from other agencies and programs. You must be careful to make certain that the instruments you use are geared to the requirements of your assessment, focus on the critical issues that have been delinated, and do not deal with extraneous material. It is better, however, to err on the side of too much rather than too little information.

STEP E. ANALYZE DATA, DETERMINE PRIORITIES, AND PREPARE REPORTS

E-1. Analyze Data

After the information has been collected, it must be analyzed in order to identify relevant problems and the general types of programs or services needed to remedy them. The complexity of the data analysis will depend on the requirements of the funding source and/or sponsoring organization, the scope of the assessment, and the amount and types of data collected. For most non-instructional programs, the data can be tabulated manually. But if a large amount of data and interrelationships among variables are to be analyzed, computer resources will be required.

In analyzing the data, a first step is to categorize the problems and needs according to the service components covered by the assessment (e.g., medical, dental, nutrition). Each problem should then be described along the following parameters:

1. Problem:	Inadequate dental care
2. Extent or Severity of the Problem:	How many people in the target group are affected, by age, sex, and ethnicity? What are the effects of the problem? How long has it existed?
3. Influencing Factors:	Is the problem caused by lack of available services, cost of services, lack of interagency cooperation, need for outreach and publicity for services, need for parent education, or other reasons?
4. Resources Available:	What agencies or programs presently exist to deal with the problem? What types of services are available? What are the program's characteristics, e.g., eligibility requirements, outreach, etc.?
5. Needed Resources/Services:	What services, program, activities are needed to deal with the problem?

Table I-5, on page 32, is an example of a problem description.

Table I-5

Problem Description

Statement of Problem: Inadequate Dental Care	
Problem Characteristics	Description
1. Extent/Severity of Problem	80% of the boys and 75% of the girls in grade 3 have dental cavities. 90% of this group are from families with earnings of $10,000 a year or less. Of the group with cavities, only 8% had received a dental examination during the past 12 months.
2. Influencing Factors	There is only one dental clinic that provides low cost care (the University Dental Clinic) and over 75% of the private dental practitioners refuse to accept patients on Medicaid. 65% of the parents were unaware of the University Dental Clinic and only 24% of the parents noted dental care as a problem of great concern to them.
3. Resources Available	University Dental Clinic, which has no outreach or preventive programs.
4. Needed Resources/Services	A program providing free or low-cost dental care for children; increased outreach by University Dental Clinic; a program of parent education regarding the importance of prevention and regular dental examinations for children.

E-2. Determine Priorities

The next step is to determine which problems/needs have the highest priority for the non-instructional program. Data analysis will reveal a number of relevant problems of varying magnitude. In all likelihood, the program will not be able to address all of them. Consequently, the Needs Assessment Team must devise a method of prioritizing the problems.

There are two broad criteria that should be used for assigning priorities:

1. Severity. This relates to #1 in Table I-5, "extent/severity of the problem." In addition to the factors listed, another question to be considered is: What is the relationship between this problem and other problems that have been identified?
2. Feasibility. This relates to #2, 3, and 4 in Table I-5. The basic questions to be considered here are: How tractable is the problem at the present time? Can a workable solution be identified and implemented? Will the program, in cooperation with other agencies, have the resources--staff and budget--necessary to address the problem? How can the program use its resources most effectively?

A knowledge of the target population, the community's institutions and resources, and the organizational context within which the program will operate are essential to a determination of priorities. In addition to this information, individual value judgments are an inevitable part of this process. The technique described in A-2 can be useful in facilitating the decision-making process. Each Team member should be asked to rank the problems, using the above criteria of magnitude and feasibility. After each member has reported his or her rankings and stated the reasons, the group should take a vote to determine the final priorities.

E-3. Prepare the Needs Assessment Report

The final step in the needs assessment process is the preparation of the report, which should be distributed to the key participants in the needs assessment process. Ideally, the report should contain the following:

1. Introduction, giving the background and purpose of the study
2. Short summary of the principle findings/problems
3. Discussion of the target population and the community (with demographic, economic, institutional, and other relevant data)
4. Explanation of how the information was collected and analyzed and how priorities were determined
5. Detailed discussion of each principle finding/problem
6. Conclusion, with suggestions for types of services to be provided

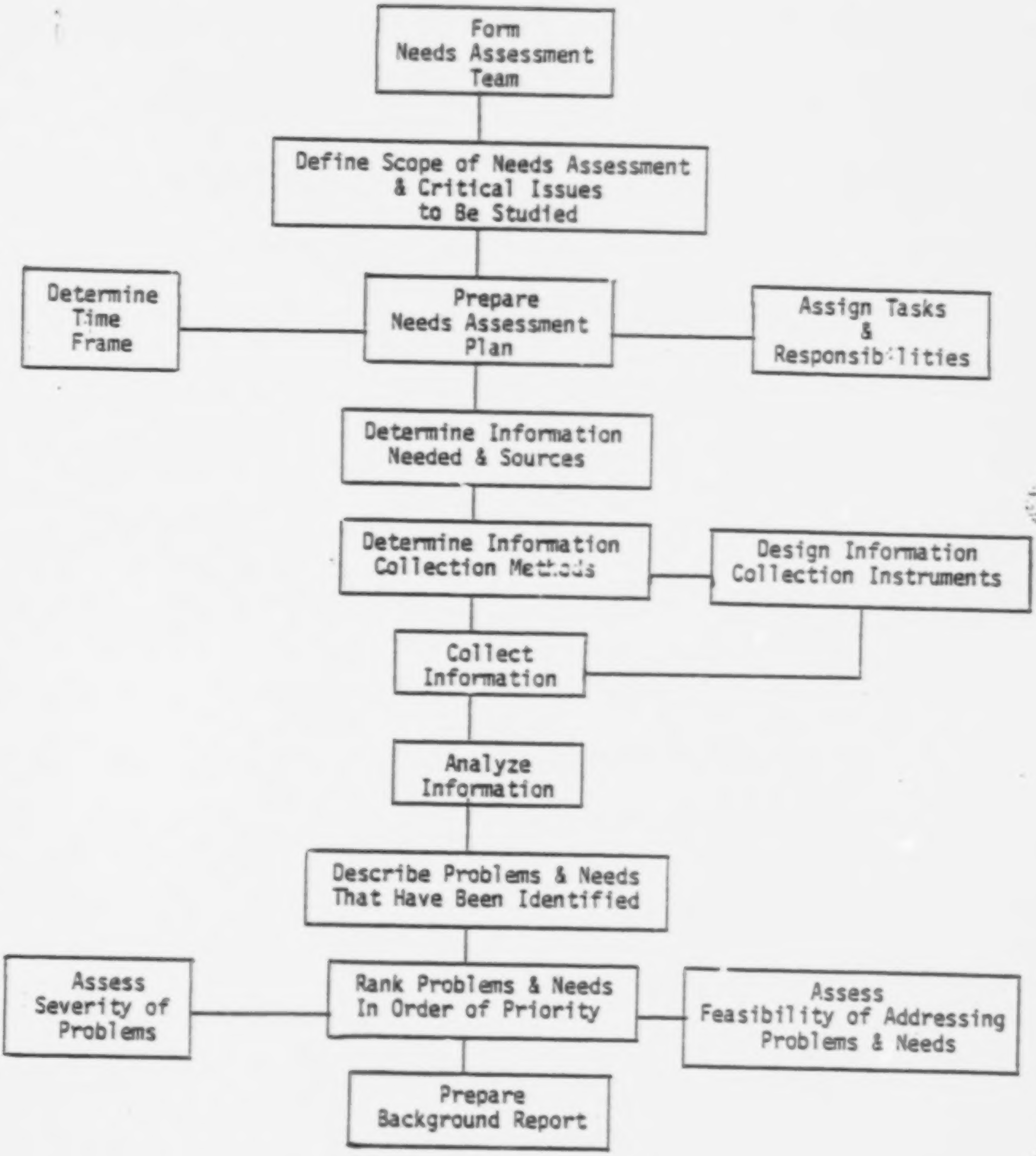
SUMMARY

Although the needs assessment should be comprehensive and thorough, it should not become inordinately complex and expensive. Through careful planning, it should be possible to gather and analyze useful data without the use of extensive resources. The key planning questions are:

- What information do we need?
- Why do we need it?
- How can we get it most efficiently?
- How will it be analyzed?

When planning the needs assessment, and when deciding which problems should receive the highest priority, it should be kept in mind that the anticipated program is for the benefit of children and families and that the goal is to improve the overall development of children in order to improve their academic performance and enhance their lives. However, it must also be borne in mind that the program will not be able to address all of the needs that are identified or even all of those that are the most severe. The question of feasibility is paramount: Are resources available at this time, or can they be obtained, to effectively address this need?

NEEDS ASSESSMENT


Form Needs Assessment Team
Define Scope of Needs Assessment & Critical Issues to Be Studied
Determine Time Frame
Prepare Needs Assessment Plan
Assign Tasks & Responsibilities
Determine Information Needed & Sources
Determine Information Collection Methods
Design Information Collection Instruments
Collect Information
Analyze Information
Describe Problems & Needs That Have Been Identified
Assess Severity of Problems
Rank Problems & Needs In Order of Priority
Assess Feasibility of Addressing Problems & Needs
Prepare Background Report

PROGRAM DESIGN

PROGRAM DESIGN

A process for planning the service delivery and management strategies required to address the priority needs that have been identified by the needs assessment process.

KEY FACTORS TO BE CONSIDERED

- Who should be included in the program design process and how much time is available?
- What are the resources and obstacles in the community that will affect the successful implementation of a non-instructional program?
- How will the structure of the sponsoring organization (e.g., school or school system) affect the non-instructional program?
- What specific services can best address the needs identified by the needs assessment?
- What type of management support system and staffing pattern will be required to carry out the non-instructional program?
- What recordkeeping systems will be necessary in order for the program to operate efficiently and effectively?
- What interagency linkages are necessary?

PURPOSE & RATIONALE

Program design is the most creative aspect of program development and flows directly from the needs assessment. Its purpose is to formulate service delivery and management strategies based on the problems and needs identified by the needs assessment process.

An analogy can be made between program design and architectural planning. In both instances the task is to develop a blueprint. Both the program designer and architect must consider the needs of the people to be served, the context or environment in which the product will be located, the resources available, and the activities that will take place.

Without a carefully thought out program design, a non-instructional program cannot possibly achieve its objectives, but it is likely to be more costly in terms of time, effort, and money.

THE PROGRAM DESIGN PROCESS

The seven major steps in the program design process are:

A. Initiate the Program Design Process
B. Review Community Organizational Factors
C. Clarify the Program's Mission: Philosophy, Conceptual Basis, and Global Goals
D. Explore Service Options and Select Specific Services to Be Delivered
E. Prepare the Service Delivery Plan
F. Prepare the Management Plan
G. Design the Monitoring System

STEP A. INITIATE THE PROGRAM DESIGN PROCESS

A-1. Assemble a Program Design Team

The Program Design Team can be the same group that planned and conducted the needs assessment, or it can be changed in composition, with members added or deleted. In any case, it should definitely include persons who were part of the Needs Assessment Team as well as persons who will be involved in program implementation, the next stage in the program development cycle.

Team members should be chosen based on their knowledge of program management and service delivery structures. In addition to the categories of persons mentioned for inclusion on the Needs Assessment Team, the Program Design Team should include individuals with program planning, legal, and financial expertise. In certain instances it may be advisable for the team to use consultants, either paid or volunteer, to design technical aspects of the program.

A-2. Outline the Purpose of the Program Design Team

Team members must be clearly informed regarding what they are expected to achieve. They should be given a history of the project: why and how it was begun and what has been accomplished to date. They should also be given a copy of the needs assessment report and any other pertinent materials that will help them better understand the project.

The purpose of the Program Design Team is to prepare a program design consisting of:

- The Program's Mission Statement (philosophy, conceptual basis, and global goal(s))
- The Implementation Plan, which consists of two interrelated parts:

  1. A Service Delivery Plan describing
     a. the services to be delivered and their objectives,
     b. a service delivery schedule, and
     c. a service delivery information and reporting system.
  2. A Management Plan describing
     a. resources that are needed,
     b. the organizational chart and job descriptions,
     c. a management information and reporting system,
     d. interagency linkages,
     e. orientation and inservice training plans, and
     f. monitoring plan.

(The specific tasks involved in developing the program design are explained in Steps B through G.)

A-3. Establish a Time Frame and Assign Responsibilities

There is no "best" amount of time to be used for program design. The amount of time allocated to the process will depend on a variety of factors, some of which are not within the control of the program. For

46

example, the funding agency or sponsoring organization may have mandated a specific amount of time for planning. If the amount of time allocated is too short, some important issues are likely to be overlooked or will have to be postponed and dealt with later. If the time for planning is too extended, interest and enthusiasm may wane. The optimum amount of time will depend on the size and nature of the program and the skill and expertise of the Program Design Team.

After the amount of time for planning has been determined, a schedule should be made designating specific tasks, deadlines, and the person(s) responsible for each task.

STEP B. REVIEW COMMUNITY AND ORGANIZATIONAL FACTORS

B-1. Analyze the Community in Which the Program Will Operate

Everyone involved in designing the program should be familiar with the assets, problems, resources, needs, services, and cultural traditions of the community. A number of definitions of community are used in different fields and disciplines. The term "community" in this guide refers to:

> A clustering, within a specific geographic area, of families individuals, groups, organizations, and institutions for the purposes of
>
> (a) socialization--the transmission of values and behavior patterns;
>
> (b) social participation--involvement in the decision-making of community groups, institutions, and businesses;
>
> (c) social control--methods for assuring conformity to established norms of behavior; and
>
> (d) production-distribution-consumption--participation in the use of services, the consumption of goods, or the production and distribution of services and goods.

Relevant information about the community should be contained in the Needs Assessment Report, described on page 33. Of particular concern are (a) the resources in the community that can be tapped for the program and (b) the factors within the community that may present obstacles or barriers to program implementation.

In many communities, churches are important resources that are often overlooked. They can disseminate information about the program and its services; they often have space that can be utilized; and they are a possible source of volunteers and other types of assistance. In addition, they sometimes sponsor programs that can be of value to the non-instructional program, and ministers are often quite knowledgeable about the culture and life-styles in the community. Other resources, such as social service agencies, health facilities, educational institutions, and cultural programs, should be identified during the needs assessment.

Factors that could present obstacles to program implementation are poor public transportation, high street crime, or a large number of single-parent families living in isolation, with no one to share babysitting chores. Car pools and various types of child care arrangements have been used to overcome such problems. A more difficult problem to overcome is parents' lack of trust in the school and its staff. The creation of trust does not occur automatically or easily, but requires clear, consistent, and regular communication between the school and parents and positive relationships between parents and individual staff members. Some techniques that have been suggested to promote parent involvement include home visits, encouraging parents to visit the school, a parent room, parent hot line, newsletters, parent handbook, opportunities for social contact between parents and staff.* Both the resources and the barriers will have a strong impact on the program's activities and when and where they are offered.

*A comprehensive guide to creating positive parent-school relationships, entitled Involving Parents: A Handbook for Participation in Schools, has been prepared by the Systems and Evaluation Department, System Development Corporation, 2500 Colorado Avenue, Santa Monica, CA 90406.

B-2. Analyze the Organizational Context in Which the Program Will Operate

Non-instructional in-school programs can be sponsored by and operate within different organizational frameworks. For example, some operate within a single school, others include several schools, and still others are conducted throughout an entire school system. If the program is to be implemented efficiently and effectively, the organizational framework must be well understood. Some basic questions that should be considered are:

- How much autonomy will the program have? Which decisions related to the non-instructional program will be made by the larger organization?
- Where is the source of authority within the sponsoring organization as it relates to the non-instructional program? Who usually has the final word? What is the power structure like and whom does it include?
- How are decisions made? Is the decision-making process flexible? Is it usually smooth or is it cumbersome?
- What mechanisms are available for the resolution of conflict?
- What material and human resources are there within the organization that can be utilized by the non-instructional program. Are there major office equipment (computers, word processors), secretarial services, resources for materials development, mailing lists of parents and community agencies? Is there a snack program or free breakfast? Are there family workers or a school nurse? Is there a family room?

STEP C. DEFINE THE PROGRAM'S MISSION: PHILOSOPHY, CONCEPTUAL BASIS, AND GLOBAL GOAL(S)

Every human service program should have a clearly articulated "mission statement" consisting of its philosophy, conceptual basis, and global goal(s). The mission statement should be clearly formulated and well understood by everyone who is involved in the planning processs, since it will provide overall direction for program planning and implementation. If the program's mission is spelled out early in the planning process, later confusion can be avoided and the program can be designed around mutually agreed upon principles.

C-1. Define the Program's Philosophy and Conceptual Basis

In all likelihood, the program's philosophy and conceptual basis were at least mentioned during the needs assessment phase. Now is the time to articulate them clearly.

The philosophy of a non-instructional program for children encompasses the social and human values on which the program is based. A possible statement of a program philosophy is:

> Society has a responsibility to enable each individual to develop to his or her maximum potential. If schools are to perform their role as one of the major institutions for the education and socialization of all children, one of their major responsibilities is to develop programs that demonstrate a concern for the total child, including its intellectual, physical, social, and emotional needs.

The conceptual basis refers to the fundamental ideas and educational assumptions on which the program is based. As stated in the introduction to this guide, the underlying concept of non-instructional programs for children is:

> If educational programs are to serve the total child, it is essential in certain communities to provide a variety of non-instructional health and social services. Optimal development and the ability to take advantage of academic/instructional opportunities require that children be physically healthy and that they be relatively free from emotional disturbances as well as debilitating circumstances in their physical environment.

C-2. Define the Program's "Global" Goal

Global Goals are the long-range, broad ends toward which the entire program is directed. The following is an example of a global goal statement for a non-instructional program:

> The goal of this non-instructional program is to provide a coordinated, comprehensive program of services and activities in medical, dental, and nutritional areas for children in grades K through 3, and related services for their families, in order to improve the children's academic performance and increase their life chances. These services will be designed to supplement those already available in the school and the community and will be provided within a context of active parental and community involvement.

Your program's mission statement provides the general direction for the program and is the basis for interpreting it to the community. It should be stated in language that can be easily understood by members of the community and should be included in the program's brochure and other materials for external as well as internal distribution.

STEP D. DEFINE GOALS AND SPECIFY SERVICES FOR EACH PROGRAM COMPONENT

D-1. Define Goals for Each Program Component

After the program's mission statement has been agreed upon, the next step is to define the goals for each component (e.g., medical, dental, nutrition). They are derived from, but are more short-range and narrowly defined than, the program's "global" goal and should be based on specific problems and needs identified by the needs assessment. Component goals should be clear and attainable. Table II-1 on page 46, provides examples of goals for medical, dental, and nutrition components. Once the component goals have been defined, the next step is to generate service options and then to select specific services.

D-2. Brainstorm for Service Options

Brainstorming is a group technique for generating ideas. It is an excellent problem-solving technique when used properly, since ideas from one person tend to stimulate ideas in others. The aim is for the Program Design Team to generate as many service options as possible for each program goal.

The chairperson or another member of the Program Design Team should lead the brainstorming session. Service options should be recorded on newsprint or a blackboard so they can be seen by all team members. Some general rules to follow when brainstorming are:

1. Designate a specific amount of time for generating service options for each goal

Table II -1

Examples of Goals for Medical, Dental, & Nutrition Program Components

Program Component	Goals
1. Medical	• to provide testing for all children • to provide necessary follow-up services for children with vision problems • to provide immunization for all children • to provide an annual physical checkup for all children • to obtain necessary treatment for children with medical problems • to provide instruction in personal hygiene to all children • to provide safety instruction to all children • to provide first aid and emergency treatment within the school • to provide workshops for parents on various childhood illnesses, e.g., asthma, childhood diabetes, hypertension • to inform parents regarding community medical facilities • to consult with all parents individually about the medical history, problems, and needs of their families
2. Dental	• to provide annual dental check-ups for all children • to obtain follow-up dental care where necessary • to provide instruction in dental hygiene for all children
3. Nutrition	• to provide supplemental nutrition program for all children • to provide nutrition education for all children • to provide nutrition education for parents

2. Discuss one goal at a time.
3. List as many service options as team members can think of. The more service options that are generated, the greater the likelihood of finding a good one.
4. Record all ideas, no matter how unlikely they seem.
5. Delay judgment. Don't criticize or evaluate service options while the brainstorming session is in progress. (This will be done in the next step.)

The following are some service options that might be generated during a brainstorming session:

Goal 1.

To provide daily supplemental nutrition to children in grades K through 3 during the spring semester.

Service Options

- a free daily breakfast
- a free daily lunch
- a free daily breakfast and lunch
- a free daily snack in mid-morning and mid-afternoon
- a free daily evening meal
- three free daily meals
- a free daily children's multivitamin
- an individualized nutrition program for each child based on a hair and/or blood analysis and a medical check-up

Goal 2.

To provide nutrition education to parents of children in grades K through 3 during the spring semester.

Service Options

- nutrition classes
- cooking classes demonstrating how to prepare tasty, low-cost nutritious meals
- a cookbook prepared by parents containing inexpensive recipes and menus
- consumer education classes
- a food buying cooperative

- a weight loss program

What are some other possible service options for these two goals?

D-3. Assess Each Service Option and Make Selections

After all the service options have been presented, each option must be assessed using the following criteria and any others your Design Team considers important:

- Is it consistent with the program's mission statement?
- Is it feasible? Will the necessary resources be available?
- Is it financially reasonable and cost effective?
- How would it relate to existing services and programs in the school and community? Are there resources in the community that could be used? What interagency linkages would be necessary?
- Are there significant barriers? Are there cultural factors that might interfere with implementation? Is it accessible to the target population?
- Has a similar service been tried before, either by the sponsoring organization or another agency? If yes, what were the results?
- How does it compare to other options that have been suggested?

After each option has been assessed, the Program Design Team can then choose those services the program will deliver. Your knowledge of the children and their families, the community, the sponsoring organization, and the resources at the program's disposal must be brought to bear on your decisions. Services that will work successfully in one setting may fail completely in another situation.

STEP E. PREPARE THE SERVICE DELIVERY PLAN

E-1. Describe Each Service and Its Objective

In Step D-2, on page 45, the specific services were selected. The task now is to describe each service and define its objective(s). The service description should include:

- time period
- participants: who and how many
- service activities
- tasks required to deliver the service
- person(s) responsible for delivering the service

A description of nutrition classes for parents might read as follows:

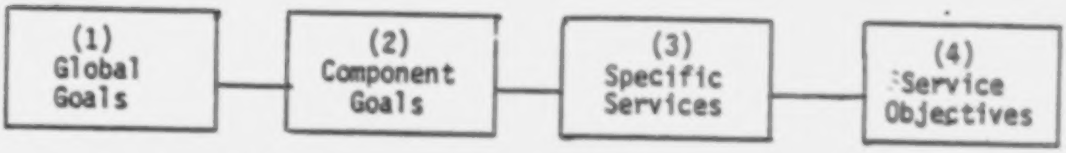
Nutrition Classes for Parents

> During the spring semester, three cycles of nutrition classes for parents will be held, each cycle consisting of four classes held once a week. Each cycle will have an enrollment of 30 parents. If space is available, classes will be open to community residents. The purpose of the class is to help parents prepare nutritious, low-cost meals for their families. Course content will cover, but not necessarily be restricted to, a description of nutrients and their roles; the elements of a well-balanced diet; how to shop for and prepare well-balanced meals on a low budget. The program's Health Coordinator will be responsible for planning the curriculum, conducting classes, securing outside speakers where necessary, obtaining course materials, and carrying out administrative tasks. The family worker will be responsible for outreach.

After the service description has been prepared, it will be useful to break down the specific tasks that are involved and the staff members who are responsible, as shown in the example below. This will be helpful in Step F when you are preparing an organization chart and job descriptions.

Tasks	Responsible Staff
Prepare Curriculum	Health Coordinator
Secure Speakers	Health Coordinator
Secure Materials	Health Coordinator
Supervise administrative details	Health Coordinator
Outreach	Family Worker

"Global Goals," defined in Step C, provide the overall direction for your program. The goals for each component outline the general types of services that will be provided. Service objectives specify what the program intends to do and the standards against which the program will be monitored.



Service objectives should be (a) concise, (b) feasible given program staff and resources, (c) attainable within a specific time period, and (d) measurable (i.e., stated in quantifiable terms). The following is the objective for nutrition classes for parents:

Purpose:	To enable parents to provide low-cost, nutritious meals for their families
Frequency:	In three cycles for four weeks each, with one class per week
Participants:	Parents of children in grades K through 3 (plus other parents and community residents if space is available)
Number of Participants:	30 per cycle (a total of 90)
Time Period:	Spring Semester

E-2. Prepare the Service Delivery Schedule

There are two basic criteria for the service delivery schedule: (a) that it allows for maximum participation of both children and parents and (b) that it does not seriously interfere with the children's academic schedule.

If most parents work or are unavailable during the day, parent activities should be held in the evenings when possible. In some communities, however, parents are reluctant to come out at night because of a high rate of street crime. If possible, it may be necessary to arrange car pools or other means of group transportation. It also may be necessary to provide child care services at the program site so that babysitting problems will not restrict parent participation.

In addition, services should be planned so that children will not consistently lose time from the same class. Also, too many services should not be planned for the same day or for too many days in one week. This would be disruptive for children as well as teachers and would in all likelihood eventually cause some resistance to the program from teachers. In order to minimize this possibility, instructional staff should be included in planning the service delivery schedule.

E-3. Design Service Delivery Process

The service delivery process includes outreach, intake, assessment, development of a service plan, service provision, and reassessment. The nature of each of these activities in a non-instructional in-school program is strongly influenced by the fact that the target population is precisely defined (e.g., "children in grades K through 3" and their families) and highly accessible, so that, for example, some of the typical outreach and intake activities that are part of most human service programs are not called for or are greatly modified.

Outreach for non-instructional programs is to two groups: children and parents. Outreach to parents is the most problematic, since it is not always easy to get parents involved in school programs. Parents must be informed of the ways in which they can participate and be convinced of the benefits of the program for their children and themselves.

Outreach to children is through parents and teachers. In order for children to participate in some services, parents will have to grant written permission, another reason why it is so necessary to convince them of the program's importance. Teachers are involved in outreach not only because they will have to release children from the classroom but also because they will be asked to include some related material in their curricula.

The two important pieces of material needed for outreach are the letter to parents and a letter or memorandum, with supporting material, for teachers.

Intake is the procedure for registering each child in the program and obtaining a history (medical, social-psychological) on each child. Some of the information to be included in this history will be available from school records, other information will have to be obtained from children and parents. In addition to obtaining client histories during intake, it will also be necessary to determine each child's eligibility for the program and/or for specific services (see Step F-1).

Parents should be included in the intake process to provide information about their children and families as well as to have any questions answered that they may have about the program.

A comprehensive intake form for recording each child's medical and social history and special problems is needed. Intake records are particularly important for program monitoring as they provide baseline data about clients.

Assessment is the process of identifying and describing the extent and nature of the client's problems. It is based on the history that was obtained during intake as well as any screening or testing that is done as part of the assessment process.

Service plans must be developed for each child based on the problems identified during the assessment. While some services, particularly those of an educational nature (e.g., nutrition education), will be designed for all the children, individual plans will have to be developed to deal with each child's special problems. The service plan for each child should contain (a) a statement of the problem, (b) a statement of the service goals, and (c) a statement regarding specific services the child will receive.

During service provision, careful attention must be given to assure that all necessary services are received, that interagency coordination

58

is maintained, that the service plan is revised as necessary, and that regular contact is maintained with parents to ensure that they are fully informed and that their full cooperation is received. During the course of service provision, it will be necessary to periodically reassess each client in order to determine whether the problem has changed and, if so, how.

Case records, which build on the intake records and are maintained during service provision, are essential for providing quality services. They should be viewed primarily as a tool for meeting the client's needs. In addition to providing a history of client contacts and tracking client progress and problems, they serve a number of other management and service delivery functions: (a) documenting services provided to clients, (b) sharing information so that workers can maintain continuity and quality of services, (c) providing a means for worker supervision, (d) providing information for program monitoring, and (e) providing a form of legal protection for the program.

The specific content and format for client records will vary from program to program. However, some general guidelines for case records are:

1. Their purpose should be clearly spelled out and understood by staff members who are responsible for maintaining them.
2. They should be complete, concise, and accurate. A clear distinction should be made between factual and interpretative material. They should contain only relevant information. What is relevant is not always easy to determine, but one guideline is stick closely to facts and keep impressions and subjective statements to a minimum. It should be kept in mind that clients may demand access to records and they can be used as a basis for legal action.
3. Records should be kept up to date. Incomplete records can cause problems for the program, for staff members, and most important, for children and families.
4. Records should be confidential.

STEP F. PREPARE THE MANAGEMENT PLAN

In a non-instructional in-school program, the primary function of management is to act as a support system to service delivery. Management provides the planning, coordination, technical assistance, and resources that will enable service delivery to operate efficiently and meet service objectives.

In many new programs there is a tendency to spend a great deal of time in staff meetings, reviewing procedures, planning activities, and discussing general staff concerns. While such activities are essential, the program manager/coordinator must take care to avoid spending too much time on general management and not enough on direct services.

F-1. Determine Eligibility Criteria

Determination of eligibility criteria is a management function since they are usually based on funding agency mandates. Two eligibility criteria for participation in non-instructional programs are income and parental permission. Most non-instructional programs are designed to serve low-income children. In some situations, children other than low-income may participate in the program but their parents may be required to pay for certain services on a sliding fee scale.

Signed parental permission slips usually are required in order for children to receive medical and dental services and participate in some activities. If such permission is not obtained, it will be impossible for the program to achieve its objectives.

F-2. Determine What Resources Are Needed

As part of management planning you must determine what resources are needed to deliver services and implement the program. For each service that your Design Team decides to provide, you will need to outline the resources needed, covering:

- budget
- personnel
- space
- equipment and supplies
- materials
- other

Most non-instructional programs must develop strategies to deliver services with a minimum amount of resources. What resources would the program need to deliver the services that your design team has selected?

F-3. Prepare an Organization Chart and Job Descriptions

Based on the personnel needs that were determined in Step F-2, prepare an organization chart showing the personnel that are needed and the supervisory-hierarchical relationships. Possible personnel for a non-instructional in-school program include:

- Program Manager/Coordinator
- Social Worker
- Psychologist
- Nurse
- Health Coordinator
- Health Aides
- Parent Program Assistant
- Family Workers
- School-Community Aide
- Secretary
- Volunteers

This list represents the possible range of job titles that might be considered for a non-instructional program. The New York City Follow Through sites averaged between 5 and 7 staff members and usually included a basic staff of program coordinator, secretary, nurse, parent program assistant, and family worker.

In addition to paid staff, volunteers, usually parents, play a key role in non-instructional programs and should be included on the organizational chart. Teachers may also be included. Table II-2, on page 60, is an example of an organization chart from a New York City Follow Through site.

After personnel needs and supervisory relationships have been determined, job descriptions including the following items should be prepared for each position:

> Professional Requirements: education, experience, skills, personal characteristics, and special requirements.
>
> General Description: major responsibilities and relationship to other staff, including supervisors, subordinates, and co-workers.
>
> Specific Functions and Tasks: a detailed description of activities required to carry out major responsibilities.

Job descriptions are important management tools that help to clarify the program's structure and operation; help the program manager make appropriate staff selections; and provide one means of orientation for personnel. The following is a sample job description for a Follow Through Staff Nurse.

* * *

Job Description

Job Title: Follow Through Staff Nurse

Professional Requirements:

Licensed by the New York State Department of Education as a Registered Nurse/ Experience working with young children and families/Knowledge of health resources in the community/Demonstrated ability to handle administrative duties.

General Description:

The Follow Through Staff Nurse is the staff member with primary responsibility, under the direction of the Program Coordinator, for planning and administering the health components (medical, dental, and nutrition) of the non-instructional program for children in Follow Through classes. She/He will supervise the Health Coordinator and/or Health Aide(s); work in a team with other senior staff members to plan, implement, and monitor an integrated program of non-instructional services; and collaborate with teachers in developing health instruction for Follow Through classes.

The nurse will play a major role in program planning. In collaboration with the Program Coordinator and other senior staff members, she/he will develop goals and objectives for the health components, design specific health services, determine what resources are needed, prepare the service delivery schedule, develop the service delivery information system, and provide input related to other non-instructional components. In addition, the nurse will have responsibility for designated administrative duties related to the delivery of health services.

62

(Job Description Continued)

Other major areas of responsibility include:

1. Case management in health care service delivery
2. Planning and coordinating interagency arrangements for health services
3. Planning and supervising nutrition supplement program
4. Collaborating with teachers to develop a health curriculum
5. Planning inservice training for staff in health areas
6. Planning workshops, seminars, and other health related activities for parents
7. Supervising the monitoring of service delivery in the health components
8. Supervising designated staff

Specific Functions:

The following functions and tasks are necessary in order to carry out the responsibilities listed above. They are to be performed by the nurse with the assistance of the Health Coordinator and/or Health Aide(s).

1. Case management in health care service delivery
    a. prepare a medical history for each child
    b. assess children's health problems, including vision and hearing screening and other tests and examinations where appropriate
    c. observe children in classroom and other in-school activities in order to detect health problems
    d. prepare a health service plan for each child
    e. supervise and monitor the delivery of health services
    f. make, and follow-up, referrals to appropriate health care agencies and private practitioners
    g. provide emergency health care to children where appropriate
    h. arrange for children to be escorted to appointments with health care providers
    i. decide when children should be excused from school for health reasons
    j. maintain contact with parents through home visits, telephone calls, and letters regarding children's health problems and health care
    k. develop necessary recordkeeping forms and instruments for health care service delivery and supervise recordkeeping procedures
    l. perform related administrative tasks

(Job Description Continued)

2. Coordinating interagency arrangements for health services
    a. in cooperation with the Program Coordinator, design interagency arrangements with voluntary and municipal hospitals, as well as private practitioners, for the delivery of health care services
    b. in conjunction with the Program Coordinator, maintain communication with health care agencies and private practitioners
    c. keep staff informed about interagency arrangements
    d. make site observations at cooperating agencies that provide health care services
    e. develop additional linkages with community agencies and programs involved in health care
    f. perform related administrative tasks
3. Planning and supervising nutrition supplement program
    a. prepare nutrition supplement schedules
    b. develop menus for nutrition supplements
    c. supervise purchasing of food
    d supervise preparation and serving of nutrition supplements
4. Collaborating with teachers to develop a health curriculum
    a. assist teachers to develop a curriculum covering various aspects of preventive health care, such as first aid, hygiene, dental care, nutrition
    b. assist teachers to prepare and select materials for classroom health instruction
    c. assist teachers to plan special health related activities for children, such as field trips, skits, health fairs
    d. assist teachers to plan special snacks for children in order to expose them to new tasty and nutritious foods
    e. provide classroom instruction on selected topics where appropriate
5. Planning inservice training for staff in health areas
    a. in cooperation with Program Coordinator and other staff, conduct training needs assessment to determine topics to be covered in inservice training
    b. design a minimum of four inservice workshops per school semester

(Job Description Continued)

   c. secure speakers and educational materials and supervise related administrative duties
   d. conduct evaluation of workshops and provide follow-up when necessary
   e. perform related administrative tasks

6. Planning workshops, seminars, and other health related activities for parents

   The following functions will be performed in collaboration with the Parent Program Assistant:

   a. design a minimum of three workshops for parents per school semester, covering areas such as consumer education; planning and serving nutritious, low-cost meals; preventive health care for children, preventive health care for adults; managing stress in children and adults; childhood illnesses and diseases; first aid and preventing accidents in the home; child development
   b. design special activities such as weight loss programs, exercise classes, swimming instruction, health fairs
   c. secure speakers and other personnel to conduct workshops and special activities when necessary
   d. perform related administrative tasks

7. Monitoring service delivery in the health components

   a. assist in designing monitoring instruments for health care delivery
   b. supervise staff in maintaining complete and up-to-date records
   c. prepare designated monitoring reports required by management
   d. use monitoring records as a supervisory and planning tool

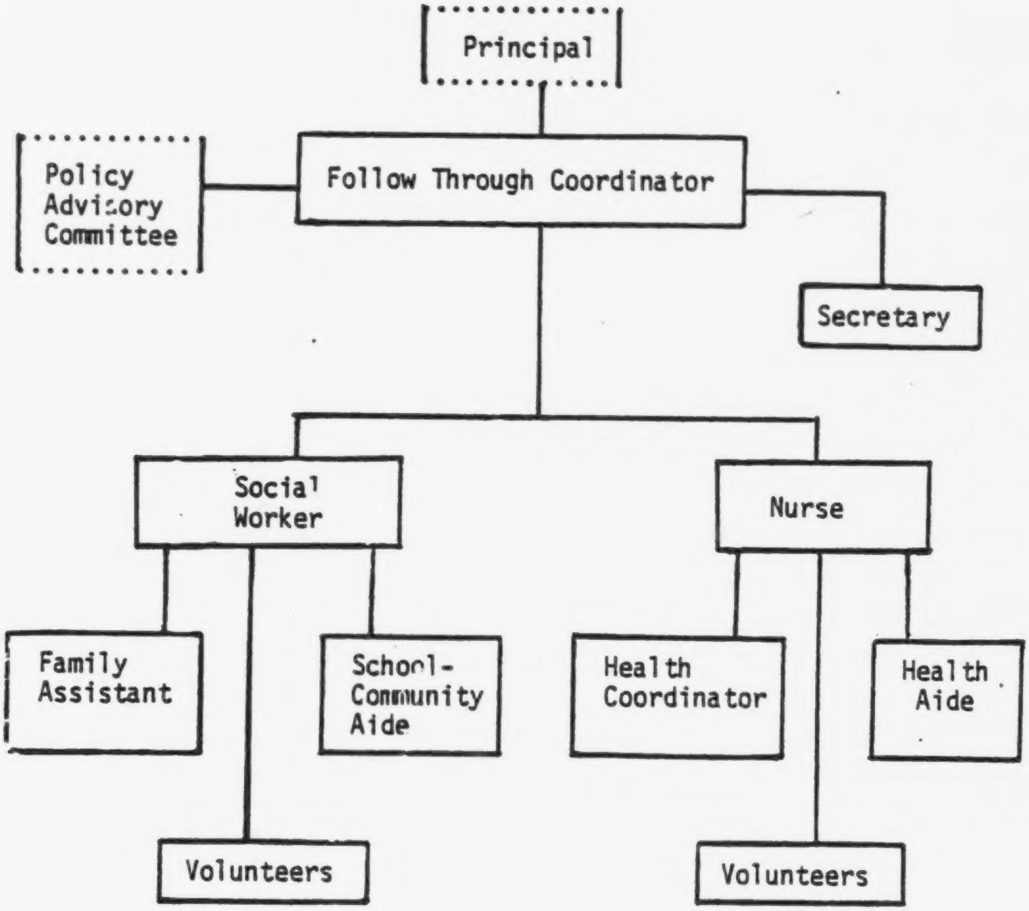
8. Supervising designated staff

   The Nurse will be responsible for the supervision and regular periodic evaluation of the Health Coordinator and/or the Health Aide(s). This will include at least one hour weekly of direct supervision as well as other supervisory conferences when needed.

* * *

Table II-2

Staff Organization Chart
Non-Instructional Program
Community School


Principal
Policy Advisory Committee
Follow Through Coordinator
Secretary
Social Worker
Nurse
Family Assistant
School-Community Aide
Health Coordinator
Health Aide
Volunteers
Volunteers

Less detailed job descriptions also should be prepared for volunteers. While some service delivery programs treat volunteers in a rather casual manner, assigning them tasks and responsibilities at random, this generally results in confusion and eventual loss of volunteer interest. Volunteers should be treated in a professional manner so that they can take pride in their work and accomplishments. They should know (a) to whom they are expected to report, (b) their hours, and (c) their duties and responsibilities.

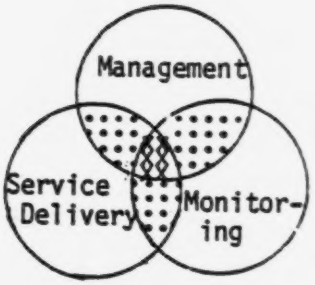
F-4. Design the Program Information System

The purpose of the program information system is to provide data that will facilitate program planning, coordination, control, assessment, and documentation. The information that is generated is used for both internal and external purposes and is designed to serve the needs of various audiences. The primary audiences are the funding agency, policy advisory committee, the sponsoring organization, program managers, and service deliverers.

For non-instructional programs, the information system is divided into three sub-systems: management, service delivery, and monitoring. Management information is generally for program planning, coordination, and control. Service delivery information is to track and assess services to clients. Monitoring information is to document and assess the program. While each of these sub-systems has its own particular information needs, there are always overlapping requirements. Consequently, the program information system should be designed in an integrated manner so that information outputs will fit into a unified framework and will meet the particular and common needs of the sub-systems. The figure on page 62 illustrates the interrelationship among the three information sub-systems.*

---

*Adapted from Evaluation of Human Service Programs, edited by C. Attkisson, W.A. Hargreaves, M.J. Horowitz, and J.E. Sorensen. New York: Academic Press, 1978.



☐ = Information that is for only one sub-system

⁙ = Information for two sub-systems

▩ = Information for all three sub-systems

The program information system consists of (1) information inputs--quantitative and qualitative information that is collected and recorded and (2) information outputs--reports that are prepared from the information that has been collected. Both inputs and outputs are based on utilization--how the information is used. The program information system, therefore, should be designed from three perspectives: the people who will use the information, the people who will record the information, and the people who will prepare the reports. In designing the system, the following decisions must be made:

> Content: What specific information is required? By whom is it required? How will it be used?
>
> Frequency: How often must information be recorded? At what time intervals will reports be prepared?
>
> Methods: How will information be collected? Who will prepare reports?
>
> Dissemination: To whom will reports be distributed? In what form?

Content

The information to be collected is based on guidelines from the funding agency and sponsoring organization and on internal program needs. As stated previously, the information system consists of three sub-systems--management, service delivery, and monitoring--each of which has its own information needs, which are outlined below.

The management information system is used primarily for program planning and to ensure that organizational tasks are implemented effectively and efficiently. It includes administrative, personnel, and fiscal data as well as certain data related to service utilization. Administrative information covers resource requirements and utilization; program policies, standards, and procedures; decision-making processes; and staff management and development. Personnel information should include job descriptions, staff experience and training, salaries and years of service, performance, and attendance. Fiscal information pertains to income, expenditures, and financial needs.

The service delivery information system includes intake records, case recrods, and service utilization data. Intake and case records have been described in Step E. Both will contain data that are also required for management control and program monitoring (such as initial problems, types of services provided, length of stay in program, and client outcomes). Much of the service utilization data also will be used by all three sub-systems. Service utilization includes information such as number of clients; sex, age, and ethnicity of clients; number and type of services delivered in each service component; number of client contacts. Where possible, all service utilization data should be organized around service delivery components (e.g., medical, dental, nutrition).

The information needed for the monitoring information system is discussed in Section IV.

When determining what information should be collected, care should be taken to guard against the following:

1. Collecting too little information, leaving large gaps.
2. Collecting too much information, so that the data become unwieldy and cumbersome. This usually also results in unnecessary repetition.
3. Not coordinating the information sub-systems, which often results in either too much or too little information being collected.

As a rule of thumb, it is better in the early stages of a new program to have too much rather than too little information. As the program progresses, the information can be streamlined.

Frequency

The frequency of information recording and reporting will vary from daily to annually. (Service delivery information is usually recorded more frequently, for example, than management and monitoring data). The information system must not only be able to produce regularly scheduled reports for internal and external needs but also must be able to respond promptly to inquiries and requests for ad hoc reports.

A frequent tendency of management is to require excessive reporting, stemming from a desire to keep currently informed and/or impose control over the staff whose work is being reported. This can result in staff spending an undue amount of time preparing reports, time that could be more profitably used for other tasks.

Methods

Information collection methods should be based on the following criteria:

- Validity: Does the method/instrument provide the information that is needed?

- Cost Effectiveness: Does the method provide information at a a reasonable cost?
- Confidentiality: Does the data collection method/instrument protect the privacy of children and parents? It is of paramount importance that client confidentiality be observed in all instances. When the method calls for contact with clients or client records, a coding system should be used.

Staff Responsibility

In assigning staff responsibility for recording and reporting information, it is generally best to have staff who are responsible for a specific task or activity to record data pertaining to it. With reports, however, it is usually wise to have them prepared by individuals with skill in report preparation if possible, particularly if these are lengthy reports intended for external distribution.

When preparing reports, care should be taken to guard against the following:

1. Insufficient support data
2. Insufficient interpretation and analysis
3. Poorly displayed data
4. Dangling information, where facts seem unrelated to one another or to an overall framework
5. Reports designed to put forth the most favorable impression and to suppress what may not seem favorable, rather than to present an objective account. While it is understandable that program staff prefer to have reports that focus on positive actions and accomplishments, it must be remembered that a basic purpose of the information system is to document progress toward goals and objectives. Another purpose is to provide data that can be used for decision-making and to improve functioning and correct mistakes. If these purposes are to be achieved, reports must be factual and objective.

Dissemination

Reports should be distributed on a selective basis, both within the program and to outside audiences. They should be sent to people who need them as a basis for taking action and to people who need them in order to be kept informed. A third group to whom reports should be distributed are individuals and agencies that the program wants to keep informed and with whom it has established or hopes to establish some form of linkage or cooperative arrangement.

Internal distribution of reports requires sensitive decision-making. While maintaining intra-agency communication and keeping staff informed of program progress are important, it is equally important not to burden staff with excessive amounts of material that either will not be read at all or that will require an inordinate amount of time to read. Staff members need information that will enable them to carry out their responsibilities and that will allow them to know how the program can best be served. Management must devise an internal information dissemination procedure that will satisfy these needs yet will not result in excessive distribution of reports, on the one hand, or in communication gaps or feelings of neglect.

The following is a brief set of guidelines for the program information system:

1. Plan the content and output of the information system in cooperation with the people who will be responsible for maintaining the system and using the information.
2. Have reports prepared on a timely schedule so that information is available when needed and can be used as a basis for decision-making and control.
3. Present reports in the language and format suited to the needs and understanding of the main recipients. If necessary, prepare different versions for different types of users.
4. Make certain that reports fully cover the topic under discussion.
5. Verify the accuracy of the data.
6. Ditinguish clearly between factual and interpretative material.
7. Reduce bulk by making certain that extraneous information is omitted.

72

Information processing is sometimes tedious and is a function that is often postponed and frequently not well done in service delivery programs. It is important, therefore, that the information system be recognized as a tool for program management and development and not viewed as an end in itself. To assure the program's information system operates efficiently and effectively requires periodic reviews to ensure that the necessary data is being collected efficiently and when needed. (Additional material on the program information system is found in Section IV: Monitoring.)

F-5. Describe Interagency Linkages

Section V deals with interagency linkages--why they are necessary, how they are established, and the different forms they can take. While the choice of specific agencies is usually based on service delivery issues, the forming and maintenance of interagency linkages is a management function, since interagency linkages usually involve administrative, financial, and/or legal arrangements.

During the program design process, decisions must be made regarding:

- Specific agencies with which your program will establish linkages
- The purpose of each interagency linkage
- The type of relationship with each agency (e.g., formal or informal)
- The role and responsibilities of each agency
- The specific services to be provided
- How linkages will be maintained and the types of communication required, including reports
- Which staff members will be involved

F-6. Plan the Orientation and Inservice Training Program

Staff performance is the crucial factor in any service delivery program and is determined to a large degree by their commitment to the program's mission.

Staff orientation and inservice training are methods for (a) providing an understanding of the program's mission, (b) developing team spirit, (c) imparting information, and (d) molding the staff's skills to the specific needs of the program.

Orientation basically serves a twofold purpose:

1. To convey the importance of the program and its relevance to children, parents, and the community.
2. To explain how the program is structured and will operate.

Orientation usually covers:

- The program's background and mission
- An overview of the sponsoring organization and its relationship to the program
- The organization structure and staff responsibilities, including the role of volunteers
- A description of program services
- A description of the program's interagency linkages

Unless there are carefully considered reasons for doing otherwise, volunteers should be included in orientation sessions along with staff. This is important to their performance and will increase their feelings of being a vital part of the program. In addition to the group orientation that is provided at the start of program implementation, later individual orientations are held for each new member. These are usually provided by supervisory staff.

Orientation should be conducted by persons who are thoroughly knowledgeable about the program as well as representatives of agencies with which the program will be working closely.

Inservice training workshops are usually designed during the implementation of the program as the specific needs of the staff become apparent. Unlike orientation, which typically is presented to all staff

74

members at the same time, inservice training is specialized and planned for specific staff members, although in some instances the entire staff as well as volunteers and parents may participate.

Although most decisions regarding specific topics for inservice training will be made after program implementation has begun, it is sometimes helpful to begin thinking about content during program design. Some inservice training workshops that have been provided by New York City Follow Through include:

- Early Child Development
- Advocacy for Children and Parents
- Case Management
- Home Visitation: The Purpose and Process
- First Aid
- Nutritional Needs of Young Children and the Affect of Nutrition on Behavior and Academic Performance
- Childhood Diseases
- Medical Screening Techniques
- Recordkeeping

Some workshops, such as early childhood development and nutritional needs of young children, should be open to parents. Other workshops that parents would find helpful include first aid and specific illnesses such as asthma, hypertension, and stress-related illnesses in children.

Institutions and individuals who can conduct training in specific areas and training materials that would be of value also should be considered during the program design stage. Possible resources include parents, staff members, staff of the sponsoring organization, local colleges, social service agencies, hospitals and other medical programs, private practitioners, adult education programs.

During the program design phase, a specific number of days should be allocated for orientation and inservice training, although in both cases the amount of time should be flexible to allow for contingency factors. Orientation for a non-instructional program can usually be covered in one or two days; inservice training days may vary somewhere between six and twelve per semester.

STEP G. DESIGN THE MONITORING SYSTEM

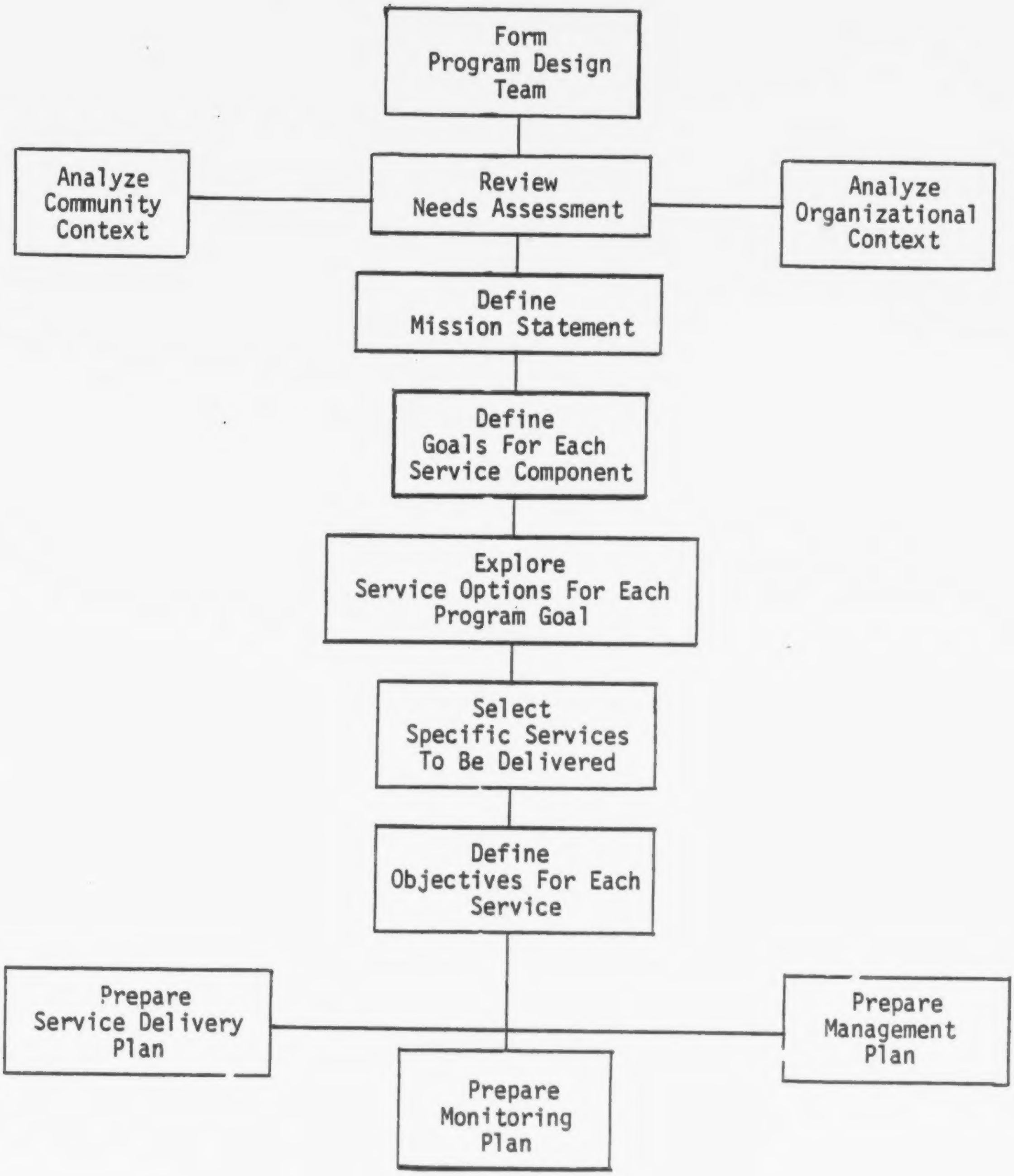
(See pages 91-97)

SUMMARY

Program design is a time consuming effort that requires a great deal of information and decision-making. While it is true that your design will in all likelihood be altered in some ways during the implementation phase, it is nonetheless important to start out with coherently conceived management and service delivery strategies based on realistic goals and objectives. Once the program design has been formulated, an operational manual should be prepared that provides program policies, procedures, and standards that are detailed enough to be easily followed and flexible enough to allow for adaptation if and when changes are required.

While all program designs for non-instructional service program share common elements, each is uniquely tailored to specific communities, children, families, and program resources. What we have described is a general process that can be adapted to meet the needs of your particular circumstances.

PROGRAM DESIGN


Form Program Design Team
Analyze Community Context
Review Needs Assessment
Analyze Organizational Context
Define Mission Statement
Define Goals For Each Service Component
Explore Service Options For Each Program Goal
Select Specific Services To Be Delivered
Define Objectives For Each Service
Prepare Service Delivery Plan
Prepare Monitoring Plan
Prepare Management Plan

PROGRAM IMPLEMENTATION

PROGRAM IMPLEMENTATION

The operation of the program based on the objectives and strategies outlined in the program design.

KEY FACTORS TO BE CONSIDERED

- How can the full participation and cooperation of existing members of the school staff be secured?
- What decision-making processes will be used to deal with unexpected events or conditions?
- What pre-operational activities are necessary in order to start up the program?
- What vehicles are available for securing appropriate staff?
- What resources are available for effective orientation and inservice training programs; how will inservice training needs be determined?
- Are the methods for internal and external communication clearly established? What types of materials are needed?
- How will interagency linkages be consolidated?

PURPOSE & RATIONALE

Program implementation is the action phase of program development. It is the process of turning the design into a reality. Whether the program is innovative or is a replication of one that is already in existence, implementation is always filled with unexpected problems and situations, regardless of the amount of careful planning.

A critical management skill, therefore, is the ability to deal creatively with contingencies--those events and conditions that occur unexpectedly. Some unplanned events that can have a serious impact on a non-instructional program are a teachers' strike, extended illness of staff members, shortages of materials and supplies, late arrival of important materials, a controversy about a major aspect of the program, a cutback in funding, a policy change by the funding agency, a policy change by the sponsoring organization, a change in the policy or program of a cooperating agency. Effectively handling contingencies as they occur will help prevent major crises.

Another critical management skill is the ability to deal with resistance. Introducing a program of non-instructional services into an established educational structure means that some of the existing staff will have to adapt to new roles, responsibilities, and routines. By including teachers and principals in the program development process, beginning with the needs assessment, it will probably be possible to reduce or eliminate resistance. However, in all likelihood, some staff will probably be somewhat reluctant to accept the new program. If feelings are strong enough, they may interfere with program implementation. There are a few guidelines that can help minimize resistance:

1. Make every effort to see that the principal or chief administrators strongly support the program, since their cooperation is vital to the program's success

and will be a major influence in determining how the program is perceived by the school staff.

2. Make certain that administrators, teachers, and other school staff clearly understand the program's philosophy, conceptual basis, goals, and objectives.
3. Make certain that school staff understand how your program will ultimately be of value to them.
4. Encourage staff input (suggestions, ideas) whenever possible.

The implemenation process--managing the program and delivering services--includes two basic types of activities: pre-operational and ongoing. Pre-operational activities are those that are necessary to start-up the program. Some will be one time events, such as securing space or purchasing major equipment; others will recur at intervals throughout the life of the program, such as hiring staff, providing orientation, devising new reporting forms and materials, revising schedules. Ongoing activities continue on a regular basis throughout the life of the program and include service delivery, case management, various management/administrative control systems, recordkeeping, report preparation and dissemination, interagency cooperation, inservice training.

THE PROGRAM IMPLEMENTATION PROCESS

The nine major steps in the program implementation process are:

A. Refine the Program Design
B. Hire Staff
C. Prepare Physical Facilities
D. Prepare Materials
E. Consolidate Interagency Linkages
F. Conduct Orientation and Pre-Operational Meetings
G. Train Staff to Implement Monitoring System
H. Develop Inservice Training Program
I. Begin On-going Operation

STEP A. REFINE THE PROGRAM DESIGN

Now that you are ready to implement the program, the program design should be thoroughly reviewed to make certain that it is still feasible and to determine if any significant changes are necessary. Actually, program design is an ongoing process, like needs assessment, that will continue throughout the life of the program. However, during the start-up period of the program, time should be devoted to an intensive re-examination of the design. Since the design was prepared, changes in policy or direction may have occurred in the funding agency or the sponsoring agency. There may also have been changes within some of the cooperating agencies. New insights into the needs of the target population may also dictate changes in the design.

A-1. Clarify Goals and Objectives

Clarity and consensus regarding goals and objectives is crucial. Before the program gets underway, all objectives should be carefully examined for clarity, feasibility, and measurability and to make certain that the necessary resources are available.

Although staff members should continually strive to accomplish the program's goals and objectives, in almost all programs issues will arise that can make the original objectives unattainable. Budget constraints, staff skills, the response of the client population, or problems with interagency arrangements may interfere. Should it become clear that it is impossible to accomplish a specific goal or objective, the staff should be able to explain why the goal or objective is unattainable and develop a new one based on the current reality. Records should be maintained to indicate clearly why a change was necessary and what the new goal or objective is.

A-2. Refine and Integrate the Service Delivery and Management Plans

Effective program implementation requires repeated review of the service delivery and management plans to determine

- whether the services to be provided are feasible and relate to the needs of the children and their parents
- whether the necessary resources are available
- if timelines are realistic, and
- what tasks must be performed to put the plans into cooperation

The service delivery and management plans must be coordinated and integrated. For example, recordkeeping and reporting systems must be coordinated, management must provide an adequate number of staff to deliver services, the service delivery plan must identify the resources to be secured by management.

It is often impossible to obtain the original resources designated in the program design. When this is the case, you will need to develop alternative resource strategies to implement the program.

A-3. Prepare an Implementation Schedule

The implementation schedule lists the major start-up and ongoing tasks and the timelines. Table III-1, on page 79, is an example of an implementation schedule for a non-instructional in-school program.

A-4. Refine the Monitoring System

(This aspect of implementation is covered in the next section on Program Monitoring.)

STEP B. HIRE STAFF

Your program may have been functioning until now with one or two staff members, e.g., a program coordinator and a secretary. Now is the time to hire remaining staff--a four-step process:

Recruitment: Conducting the search for job applicants.

Screening: Selecting those applicants who meet the basic job requirements and whom you would like to interview.

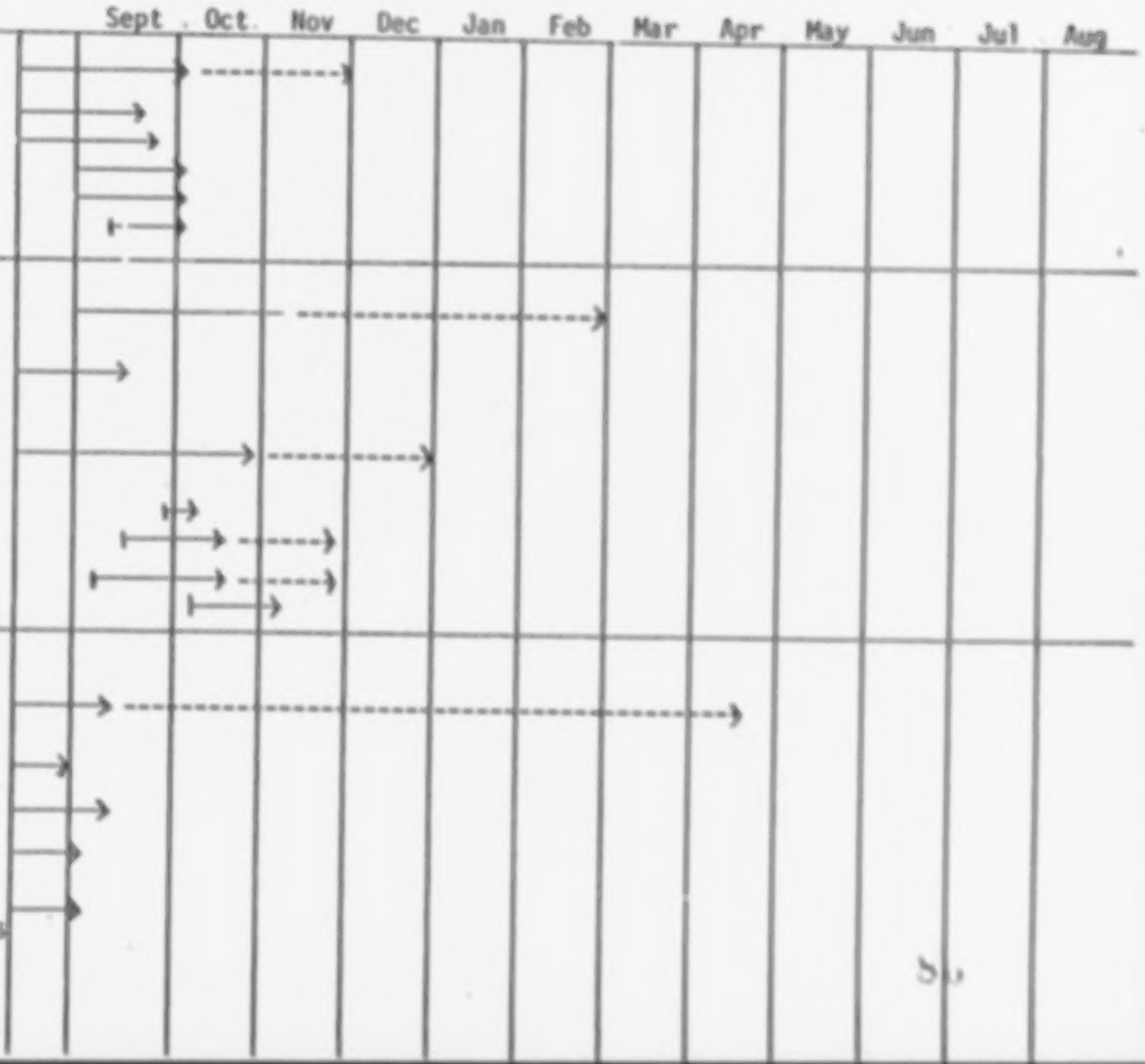
Interviewing: Meeting with the applicants to determine which have the necessary personal as well as professional requirements.

Selection: Choosing and making a formal agreement with the applicants who seem best qualifeid to work with the program.

In some non-instructional programs the hiring process must conform to procedures established by the sponsoring organization or funding agency. In Follow Through it is required that parents of Follow Through children and other low-income persons be given preference for non-professional and paraprofessional positions. Follow Through also requires that the Policy Advisory Committee be primarily responsible for recommending and choosing persons for staff positions. Some sponsoring organizations may require that job applicants first be recruited among persons already employed within the organization. In most situations it is required that all job openings be publicly announced.

Table III-1
Implementation Schedule

I PRE-OPERATIONAL &
START-UP TASKS



°**Select Staff**

- -recruit
- -screen
- -interview
- -select
- -hire

°**Refine and Integrate Management and Service Delivery Systems**

- a. review the proposal and contract
- b. establish procedures for coordinating and integrating management and service delivery systems
- c. specify staff roles and to whom they report to
- d. refine service delivery forms
- e. refine management forms
- f. refine monitoring forms

°**Initiate Fiscal and Budgetary Processes**

- a. analyze budget; make quarterly expenditure estimates and projections
- b. open bank account
- c. install bookkeeping, payroll, inventory, and voucher systems
- d. institute appropriate internal budgetary control
- e. institute financial data collection process for monthly financial planning and statements

Table III-1 (Cont'd.)

Implementation Schedule

I PRE-OPERATIONAL & START-UP TASKS		Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
°Conduct orientation			→										
°Train staff in use of monitoring system			—	→ - -	- - -	- - -	- - →						
°Clarify and consolidate interagency linkages		⊢ —	—	→ - -	- - -	- - -	- - →						
II ON-GOING ACTIVITIES													
°Deliver services (Note: List each service separately.)		⊢ —	—	—	—	—	—	—	—	—	—	—	— →
°Monitor program	- - -	- - -	⊢ —	—	—	—	—	—	—	—	—	—	— →
°Prepare reports (Note: List reports to be prepared on a weekly, monthly, quarterly, semi-annually, and annual basis.)													
°Conduct inservice training				→		→		↦		↦		↦	
°Hold staff conferences	—	—	—	—	—	—	—	—	—	—	—	—	— →

In any case, it is likely that some of your staff will be persons who have been transferred from other parts of the sponsoring organization. Since a good staff is the backbone of any service delivery program, don't be in too great a hurry to get started and thus settle for people who may become a liability to the program. This means that you may have to negotiate sensitively with the sponsoring organization to resist hiring people who are clearly inappropriate.

One of the key requirements for staff of a new, innovative program is flexibility--the ability to cope with uncertainty, to adapt to change, and to be creative. Inflexible staff can be a serious handicap for a fledgeling program, where job roles and responsibilities may be altered to meet program needs and where a full team effort is essential.

STEP C. PREPARE PHYSICAL FACILITIES

The importance of an efficiently organized, attractive environment is commonly overlooked. But a carefully designed environment can make the work go more smoothly and have a positive impact on the morale of staff, children, and parents.

A focal point of most non-instructional programs is a family room where parents can meet informally and a variety of activities can take place. Often the family room is equipped with kitchen facilities so that parents can prepare food and meals as part of their nutrition education as well as for social occasions. The room sometimes is used for parent workshops. Having a space designated for their use helps parents feel more comfortable in the school and gives them a sense of involvement in their children's education and in the non-instructional program. Creating a feeling of participation and trust is particularly crucial in low-income communities, where there is often a feeling of alienation between parents and the school.

Anotner important area is the health room, where screening and other health services take place. This room should be efficiently designed and have the necessary equipment and supplies. All areas should be clearly designated and materials should be easily accessible. The room should be attractively and brightly decorated so that it will have a positive effect on children when they enter. Children, like adults, are emotionally responsive to colors, and research has indicated that color can have a physical as well as a psychological effect.

STEP D. REFINE THE PROGRAM INFORMATION SYSTEM AND PREPARE MATERIALS

Materials must be prepared for internal and external distribution. Final decisions must be made as to what their purpose will be, who will prepare them, their content and format, how they will be produced, and how and when they will be distributed.

At no stage of a program's development is effective communication more important that at the beginning, when it is essential that everyone get an accurate perception of the program. Many problems in program implementation can be avoided or reduced if communication, both internal and external, is initiated early and systemically and maintained throughout the life of the program.

In preparing materials for external distribution, the audiences you must be concerned with are the funding agency, the sponsoring organization, parents, cooperating agencies, and the community at large. It is particularly important that materials written for external distribution be clearly written, written at the appropriate level of readability for the intended audience, and attractively presented. A key rule is that format should enhance content.

Some materials the program will need to produce are:

For Internal Use

- operational manual
- program description
- organization chart with a brief job summary of each staff position
- implementation schedule
- recordkeeping forms
- a list of community agencies, with key staff
- a list of program staff, with job titles, location, telephone number (i.e., a manning table)

For External Use

- a descriptive brochure
- a letter to parents
- parental permission slips (for children to participate in services)
- newsletter
- fact sheets
- annual reports
- news releases

The letter to parents explaining the program is one of the most important pieces of material the program will need. It must be clear, informative, and persuasive, since one of its chief purposes will be to convince parents of the importance of the program. If parents are not convinced of the merits of the program, they will be hesistant about becoming involved themselves and may not sign the permission slips needed for children to participate fully.

STEP E. CONSOLIDATE INTERAGENCY LINKAGES

Interagency relationships were initiated during needs assessment and were spelled out during program design. During the start-up period of program implementation they must be clarified and consolidated.

Some of the relationships will be formal and based on written agreements; others will be informal and loosely structured. Contracts or letters of agreement should be prepared and signed for all formal relationships. It is often advisable to have these prepared or reviewed by a lawyer, depending on their complexity and whether financial arrangements are involved. Consolidating informal linkages may require correspondence or meetings with individuals, groups, and agencies to bring them up to date on the program's services and objectives, to explore avenues for interagency cooperation, and to get an assertion of their commitment. Descriptive brochures and fact sheets should be sent to all community agencies.

STEP F. CONDUCT ORIENTATION AND PRE-OPERATIONAL MEETINGS

Careful thought should be given to the structure and content of orientation since it sets the tone for what is expected of the staff and volunteers. Very often this will be the first opportunity for the entire staff to meet together, so it is important to provide opportunities for interaction. It is also during orientation that some of the materials prepared for internal use will be distributed.

The staff meetings held during the start-up phase are a continuation of the information sharing process begun during orientation. Here, however, the primary focus is on planning, problem solving, and team building.

STEP G. TRAIN STAFF TO IMPLEMENT MONITORING SYSTEM

(This aspect of implementation is covered in the following section on Program Monitoring.)

STEP H. DEVELOP INSERVICE TRAINING PROGRAM

Inservice training is intended to help staff learn new skills or information. If the decision is made, for example, to have vision screening done by volunteers or teachers, it will be necessary to train them. Or if after several months it becomes apparent that home visits and parent outreach are not producing the desired results, it may be necessary to have inservice training in this area. One method for determining inservice training needs is to conduct a training needs assessment--ask staff to examine their job responsibilities and performance and suggest training topics that would help them improve.

After training has been conducted, trainees should be given an opportunity to provide feedback as to its effectiveness. However, on-the-job performance is the best measure of training effectiveness.

STEP I. BEGIN ONGOING OPERATION

Although ideally all of the start-up activities should be completed before ongoing tasks begin, this is rarely possible. Nonetheless, if ongoing operation is started without certain management and service delivery aspects in place, it will result in a loss of program efficiency. The following tasks are part of ongoing operation. The order of the listing corresponds roughly, but not exactly, to a time sequence, since many of the tasks will be initiated concurrently.

Task 1: Announce program to parents and community.

Before the program actually starts, letters describing the program's mission and services should be mailed to parents. Brochures and/or flyers should be mailed to community agencies and groups, and a news release should be distributed to citywide as well as local newspapers.

Task 2: Implement management control systems, including recordkeeping and systematic internal communication.

Management control systems, including personnel, fiscal, and administrative recordkeeping, should be fully developed and in operation. Internal communication systems should be designed in a manner that will guarantee that all staff receive the information that is required in order to perform their jobs effectively. Inadequate internal communication is a frequent complaint in all types of programs and is a cause of inefficiency and lowered morale and can sometimes have serious consequences for the program as well as the clients.

Task 3: Deliver services on a regularly scheduled basis, using case management procedures outlined in the program design.

Service delivery should begin as soon as possible, starting with whatever intake procedures have been designed. If service delivery is not initiated promptly, it will be extremely difficult for the program to meet its service objectives.

Task 4: Implement the service delivery and monitoring recordkeeping system.

Monitoring should begin as soon as the program begins ongoing operation, although certain aspects will have been initiated during the start-up phase. It is especially crucial that at this point all the data collection instruments and procedures are clearly established.

Task 5: Prepare and review management, service delivery, and monitoring reports on a regularly scheduled basis.

It is not unusual for social service providers to have a slight aversion to recording data, preparing reports, and using written reports as a basis for action. After it is ascertained that program information is being regularly recorded and reports are being prepared, it is essential to make certain that records and reports are actually utilized as a method of program control. A second major requirement is making certain that selected reports are disseminated to appropriate persons outside the program.

Task 6: Conduct and record regularly scheduled staff meetings to plan, review, and assess program management and service delivery.

Regularly scheduled staff meetings are important in any agency. They are a basic method of information sharing and problem-solving. It is important that the agenda for each meeting be carefully prepared in advance so that the meetings will be perceived by the staff as useful to themselves individually and to the program as a whole.

Task 7: Plan, deliver, and assess inservice training workshops.

A basic weakness in many programs is the assessment of inservice training. While assessment is not easy, it is important to determine not only whether the participants felt the training was worthwhile but also whether it had any impact on their performance.

Task 8: Maintain linkages with all relevant agencies, groups, and individuals.

Interagency linkages are the life blood of non-instructional in-school programs, and consistent communication of various types is required in order to keep them in good condition.

Task 9: Prepare annual reports and disseminate them to all appropriate agencies, groups, and individuals.

In many social service and other types of programs, it is customary to prepare a comprehensive, in-depth annual report for distribution to specific audiences and a summary for other organizations and individuals.

SUMMARY

Program implementation will test the serviceability of the needs assessment and the program design as well as the skills, ingenuity, and commitment of the staff. While careful planning lays the foundation for effective implementation, dedication and flexibility are required if the program is to be successful. Staff members must be prepared to cope with the unexpected and be willing to sometimes go beyond their job descriptions in order to assure that quality services are delivered and that program objectives are achieved.

Perhaps one of the most essential ingredients for successful program implementation is the maintenance of appropriate communication, both internal and external. Internal communication is necessary to keep staff knowledgeable about factors that affect them, their jobs, the children, and the program. It is also essential for maintaining a high level of morale, which is necessary for successful job performance. However, inadequate internal communication is a major failing of many programs. Regular external communication, particularly with parents and cooperating agencies, is also crucial. Failure to keep significant groups informed about program progress and relevant changes in program design and strategies can result in a breakdown of trust and involvement.

In essence, therefore, quality staff combined with good information and communication strategies and a well designed program will help overcome many roadblocks that occur during program implementation.

PROGRAM MONITORING

PROGRAM MONITORING

A systematic procedure for program documentation and analysis in order to determine whether the program is being implemented efficiently and is meeting its service delivery and management objectives.

KEY FACTORS TO BE CONSIDERED

- What are the program's objectives?
- What are the monitoring requirements of the funding agency and sponsoring organization?
- What information is needed for program monitoring and how can it be collected?
- Who are the audiences for which the monitoring data will be collected?
- At what time intervals must the information be collected?
- How will monitoring reports be prepared?
- How will the data contained in the monitoring reports be used to improve the program?

PURPOSE & RATIONALE

The general purpose of monitoring is to assure program accountability by determining whether the program is achieving its goals and objectives. Some specific purposes are to:

- document the services that are being provided
- document staff performance
- document how program resources are being utilized
- determine the impact of the program on its clients
- identify problems and needs within the program
- facilitate decision making and program planning
- provide a program history

Broadly, the monitoring process should answer the following basic questions:

- What was planned?
- What actually happened?
- How was it done?
- What was the effect?

Most funding agencies require a detailed description of how program managers intend to monitor the program. Indeed, many funding agencies have stringent monitoring requirements, and the reports generated by the monitoring process have a strong bearing on whether the program will be refunded. In addition, monitoring is increasingly viewed by managers as an essential management tool that can help eliminate problems or resolve them before they reach crisis proportions.

THE MONITORING PROCESS

The four major steps included in program monitoring are:

A. Develop the Monitoring Plan
B. Implement the Monitoring Plan
C. Report Findings
D. Incorporate Findings into the Program Design

STEP A. DEVELOP THE MONITORING PLAN

Monitoring is a specialized management function. However, the entire staff should be involved in the development of the monitoring plan in order to assure that the needs of the people who are to do the recording and reporting will be considered. The monitoring plan details the kind of information required, sources of information, methods of collecting data, timelines, reporting formats, and utilization mechanisms. Although the program manager has the overall responsibility for planning and supervising the monitoring process, day-to-day monitoring tasks are carried out by other staff members. Where staff resources are available, the manager may appoint another staff member to supervise the process.

A-1. Review the Program Design

The program design, together with the funding contract and the implementation schedule, will dictate the types of information that must be collected and at what time intervals. These materials should be reviewed and discussed by staff so that they become familiar reference points. Service objectives are of particular importance since they are the basic criteria that will be used for analyzing program implementation and service delivery.

A-2. Determine General Informational Needs

The information that is gathered should answer the following general questions:

1. Are the performance standards established by the funding agency and sponsoring organization being met?
2. Are the service delivery objectives being attained?
3. Are management and service delivery activities well integrated?
4. Are staff members completing job tasks on time? If not, why?
5. Are the services delivered as planned? If not, why?
6. How do the children and parents respond to the services they receive?
7. How does the program relate to other community agencies?

The specific information needed to answer each of the above questions, as well as others that your program may decide upon, should be clearly spelled out. For example, to answer question #2, "Are service delivery objectives being accomplished?" you will need to know:

- the specific services being delivered,
- to whom the services are being delivered,
- the number of people receiving the services,
- the time period during which the services are delivered, and
- whether the services are achieving their purpose.

A-3. Determine Informational Needs of Specific Audiences

Decisions must be made as to the type of information to be provided to specific audiences, in what form, and at what time intervals. The funding contract, program design, and interagency linkages will determine the primary audiences who should receive monitoring reports. Some audience categories are:

- Funding Agency
- Sponsoring Organization
- Program Staff
- Policy Advisory Committee

- Community Agencies
- Parents
- Program Replicators
- Community at large

After the audiences have been identified, each category's informational needs should be determined. For example:

> The Funding Agency usually will require on a quarterly, semi-annual, and annual basis the number of clients served with identifying data, the units of services delivered, staff compliance with funding guidelines, and fiscal reports.
>
> The Sponsoring Agency will require information on a monthly or quarterly basis which covers contract compliance, service delivery statistics, status of interagency arrangements, and management summaries.
>
> The Program Manager will need weekly information summaries on actual and projected management and service delivery performance in order to oversee the program, determine where problems exist, and attempt to resolve them.
>
> Program Replicators, who are interested in providing similar programs, will need annual as well as special reports detailing the program's ability to implement the program design and achieve its objective, the extent and effect of variances from the program design, problems that occurred and how they were resolved, and the impact of the program.

In some instances, audiences will have similar information needs; in other instances, specific questions or data will have to be developed to meet the needs of particular groups. A good rule is to write a question as though a particular group was asking it. For example, the following questions might need to be asked to answer fully the question: "How does the program relate to other community agencies?"

Audience	Question
Program Replicators	"What procedures are necessary to get cooperation from the pediatric clinic of the local hospital?"
Funding Agency	"What is the cost per visit?"

Program Manager	"What is the average number of clinic visits per child?
Parents	"What must be done to obtain medical services for my family at the health maintenance program of the local hospital?"

A-4. Identify Sources of Information

Where the information can be obtained must now be determined. Some sources of monitoring data are:

Management Data

- funding contract
- program design
- operational manual
- implementation schedule
- administrative memoranda
- administrative reports
- personnel records, including job descriptions and staff performance reports
- inservice training reports
- arrangements with cooperating agencies
- fiscal reports
- minutes of staff meetings

Service Delivery Data

- funding contract
- program design
- operational manual
- implementation schedule
- intake and case records
- service and utilization reports
- children and parents
- cooperating agencies

A-5. Select Information Collection Techniques

Several techniques can be used to collect monitoring data. Preference should be given to those that yield the desired information in the least troublesome and costly manner. Data collection techniques include:

Review of Management and Service Delivery Records and Reports: fiscal reports, personnel records, intake records, case records, minutes of staff meetings, inservice training evaluations, etc.

Interviews: with staff, Policy Advisory Committee, children and parents, personnel of other agencies.

Questionnaires/Surveys: for staff, children and parents, personnel of other agencies.

Observations: of staff meetings, service delivery.

Site Inspections: of service facilities.

The decision as to which data collection techniques to use will depend on information needs, amount of time and resources available, and the skill and experience of the personnel who will implement monitoring tasks.

Five general criteria should be kept in mind when choosing techniques or preparing instruments for collecting monitoring information:

1. They must reflect the reporting requirements of the funding agency, the sponsoring organization, and the program.
2. They must accurately measure progress toward the program's objectives and must provide a comprehensive picture of the program's management and service delivery activities.
3. They must provide data at regularly scheduled intervals, and when necessary.
4. They must permit easy recording and retrieval of data.
5. They must protect client confidentiality.

Attempts should be made to design instruments and methods that require a minimum transfer of data, particularly quantitative data, since the more often data are transferred, the more likely it is that an error will be made.

Some of the instruments used for monitoring will already have been designed for the management and service delivery information systems.

Others must be designed specifically for the monitoring system. While many programs design their own data collection forms, instruments from similar programs or from cooperating agencies can be useful. Libraries are also a good source of sample instruments that can be redesigned or modified to meet the specifications of your program. In addition, the funding agency will usually mandate certain monitoring instruments that must be used.

A-6. Develop a Monitoring Schedule

Monitoring information is generally collected on a weekly, monthly, or quarterly basis, depending on external and internal requirements. After a monitoring schedule has been developed, which states exactly how often each type of information is to be collected, a chart of reporting deadlines, with dates and staff responsible, should be prepared. The following are examples of the kinds of monitoring reports that should be required and how often.

Reports	Frequency
Service Delivery: Statistical data on units of service delivered, including cases opened, cases closed, number and type of client contacts, number of clients with age, grade level, sex, ethnicity.	Weekly
Operational: Narrative summary of the status of management and service delivery implementation, covering match between clients' needs and services offered, staff performance, inservice training, interagency arrangements.	Monthly
Program Progress: Summary of service delivery and operational data.	Quarterly
Internal Program Assessment: A review of compliance with policies, standards, procedures, and objectives established in program design. Identifies problems and recommends corrective action.	As Needed

Reports	Frequency
Client Satisfaction: Survey of parents and children, using questionnaires and interviews, to determine client assessment of program impact.	Semi-annually
Fiscal: Income, expenditures, and available financial resources.	Monthly

STEP B. IMPLEMENT THE MONITORING PLAN

B-1. Train the Staff to use the Monitoring System

The staff members responsible for designing and supervising the monitoring system must now train the remaining staff in how to implement it. This should take place in both group settings and on a one-to-one basis. Meetings should be conducted to familarize staff members with the total system and to provide an opportunity for exchanging ideas, which may result in alterations in the plan. Individual sessions should then be conducted to ensure that each staff person understands his or her specific task(s). An important part of the training is to make the staff aware of the value of monitoring for themselves, the clients, and the program.

B-2. Begin Monitoring

The monitoring plan will have been developed during the program's "start-up" stage. Monitoring should start simultaneously with "ongoing" program implementation. The monitoring process should be watched closely during the first month or two to determine:

- Are deadlines being met?
- Is the necessary information being collected?
- Is the information easily recorded, retrieved, and analyzed?
- Are reports comprehensive and useful?

Answers to these questions and others will test the effectiveness and efficiency of your monitoring system. If the answer to any of the above questions is "no", the instruments and/or process will have to be modified, or staff will need further training.

B-3. Refine the Monitoring Plan

After the monitoring plan has been in use for at least three months, it should be reviewed to determine whether it is achieving its purpose, whether it is efficient, and whether it is being properly implemented. If the answer to any of the above questions is "no," the plan should be refined accordingly, or staff should be retrained. Because of the complexity of the monitoring process it is to be expected that changes of some sort will be required after the plan has been tested.

STEP C. REPORT FINDINGS

When preparing monitoring reports, the needs of specific audiences should be considered: For example:

- Will a ten-page report to the school board have as much impact as a thirty-minute presentation with overhead transpariencies of graphs showing program impact?
- Will a detailed analysis of all program components help local physicians understand and support the program, or will a two-page summary of medical services with a covering letter be more persuasive?
- Will a filmstrip or slide presentation with narration be more appropriate for community groups than a detailed written report?

The way information is presented affects how it is received, valued, and acted on. Some issues that must be considered when preparing reports for specific audiences are:

- If the data are complicated or possibly confusing, explain them.
- Include charts or graphs to highlight dramatic results or summarize information.
- If face-to-face meetings will foster discussion of the information and its implications, arrange them.
- If the results point to significant problems in program operation, present the information in a way that suggests the source of the problems and possible solutions.
- When presenting staff or others with information regarding the results of their own efforts, personal communication is important, whether the report reflects serious problems or important successes.

STEP D. INCORPORATE FINDINGS INTO THE PROGRAM DESIGN

One of the primary purposes of program monitoring is to provide data that will facilitate future decision-making regarding program design and implementation, which are ongoing processes. If the monitoring has been well planned and executed, it should provide a wealth of information that can be used to improve the program. The first step is to review the findings of the monitoring process in relation to the following question: Is the program meeting its objectives? In response to this question, the checklist on page 100 should be completed for each objective. Based on this review, the program staff should then consider how the program can be improved. The checklist on page 101 contains some courses of action that might be required.

REVIEW OF MONITORING DATA

If the objective was met, why?	If the objective was not met, why not?
1. Objective was set to low___	1. Objective was unrealistically high___
2. Problems were not as bad as had been expected___	2. Problems were worse than had been expected___
3. The staff had the necessary skills and experience___	3. Staff performance was inadequate___
4. Sufficient resources were available___	4. Sufficient resources were not available because of poor planning___ and/or unexpected cutbacks in funding___
5. Interagency cooperation was effective___	5. Interagency cooperation was not effective___
6. Activities used to achieve the objective were effective___	6. Activities used to achieve the objective were ineffective___
7. Other___	7. Other

CHANGES INDICATED BY MONITORING DATA

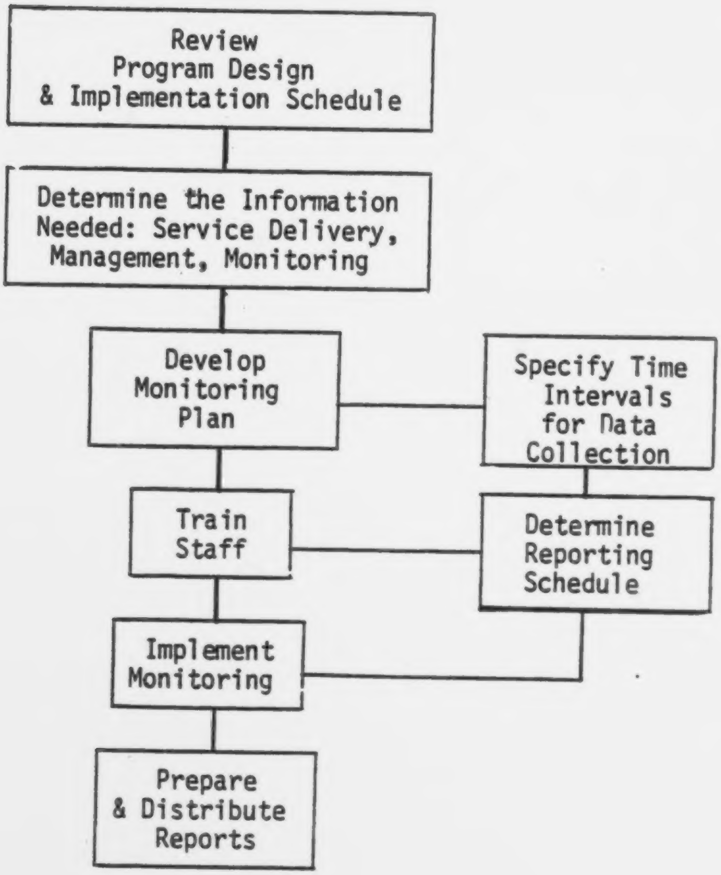
	YES	NO
Expand services	___	___
Reduce services	___	___
Redesign services	___	___
Add new services	___	___
Eliminate some services	___	___
Reassign staff responsibilities	___	___
Expand staff	___	___
Reduce staff	___	___
Reduce staff turnover	___	___
Provide additional inservice training	___	___
Seek additional funding	___	___
Reallocate financial or other resources	___	___
Develop new interagency linkages/cooperation	___	___
Redesign some interagency arrangements	___	___
Sever some interagency linkages	___	___
Other	___	___

SUMMARY

As stated earlier, monitoring is an invaluable management tool that can be used to direct and control the program. In many ways, it is a continuation of the initial needs assessment, and its findings should be helpful in redefining problems, needs, and objectives and in redesigning the program.

The monitoring process is conducted primarily by the program staff. However, in most instances the sponsoring organization and the funding agency will also do some form of monitoring, usually consisting of on-site observations, interviews, and questionnaires. Whoever conducts the monitoring, the purposes, processes, and underlying principles remain the same.

PROGRAM MONITORING


Review Program Design & Implementation Schedule
Determine the Information Needed: Service Delivery, Management, Monitoring
Develop Monitoring Plan
Specify Time Intervals for Data Collection
Train Staff
Determine Reporting Schedule
Implement Monitoring
Prepare & Distribute Reports

INTERAGENCY COOPERATION

INTERAGENCY COOPERATION

Involves establishing linkages with other agencies and programs for the sharing and exchange of ideas and resources in order to enrich the non-instructional program as well as the community's service delivery system.

KEY FACTORS TO BE CONSIDERED

- With which agencies and programs should the non-instructional program develop interagency linkages and why?
- What specific types of interagency linkages are needed?
- Has the proper groundwork for effective interagency cooperation been laid during each phase of the program development process?
- What types of communication methods are necessary in order to maintain effective interagency cooperation?
- Which non-instructional program staff members will be responsible for maintaining interagency linkages?

PURPOSE & RATIONALE

Cooperation among human service programs is a social service problem of long-standing concern. For non-instructional programs, effective cooperation and coordination with other programs can often mean the difference between maximizing services to children and families or the demise of the program.

While it is important for all human service programs to establish linkages with other programs, cooperation is the life blood of non-instructional programs. Non-instructional programs are dependent on the sharing of resources and information, and their service delivery strategies must be coordinated with other human service agencies since it would be impossible for any non-instructional program to provide directly the range of services that are required to meet the needs of children and their families. The provision of medical, dental, nutrition, social, and psychological services all depend on structured relationships with other programs.

Effective interagency linkages require planning at two levels: the administrative level and the service delivery level. If the planning is well designed, interagency linkages can:

1. reduce fragmentation and duplication of agency activities
2. strengthen existing services and generate new ones
3. increase the accessibility of services
4. strengthen communication among agencies and thereby enhance planning and problem-solving efforts
5. provide increased opportunities for staff development
6. enrich and energize individual agencies as well as the community's entire human service network

Lack of interagency cooperation, which is characterized by inadequate and fragmented services, interagency conflict, and wasteful duplication of resources, will ultimately harm the people the programs are intended to serve.

Systematic and productive interagency cooperation is not easy to achieve. It requires sensitive planning, communication, and negotiating skills. It is, however, indispensable for non-instructional programs if they are to achieve their goals, and should be guided by the following six basic principles:

1. The total community has a responsibility for the well being of children and families.
2. The interests of the children and their families must be given the highest priority at all times.
3. The participating agencies must feel that the interagency arrangement is consistent with their mission and is helping them achieve their goals and objectives.
4. The personnel of the cooperating agencies must be involved in the preparation and design of interagency arrangements, e.g., procedures, schedules, exchange of resources.
5. Agency personnel must clearly understand the cooperative arrangement and how it affects their job function.
6. Information pertaining to common goals and objectives must be shared.

This section on interagency cooperation is meant merely to outline the major steps in the process and to integrate the information on the topic contained in the other sections. Interagency cooperation should begin during the needs assessment phase and should be an integral part of the total program development process. The interagency activities that are related to each phase of non-instructional program development are outlined in Table V-1, on page 109.

INTERAGENCY COOPERATION PROCESS

The four major steps in developing interagency cooperation and linkages are:

A. Identify and Describe Community Agencies
B. Define Interagency Linkages
C. Implement and Maintain Interagency Linkages
D. Monitor Interagency Linkages

STEP A. IDENTIFY AND DESCRIBE COMMUNITY AGENCIES

Identifying agencies that can be considered for various types of interagency cooperation is one of the first steps in the program development process and takes place during the needs assessment phase. In every community there are a number of agencies that address in some manner the needs of children and families that are potential linkages for the non-instructional program. These include, but are not limited to, hospitals, clinics, mental health programs, day care centers, other educational institutions, and religious institutions.

The names of agencies usually can be obtained through various sources, such as city agencies and federations of private agencies. In some communities, directories of human service agencies have been prepared. If this information is not available, one of the tasks of the Needs Assessment Team will be to prepare a list of all relevant agencies in their community. Table V-2, on page 111, lists different types of agencies that should be included as well as the non-instructional program components to which they might relate.

117

Table V-1

Interagency Cooperation and Program Development

Program Development Phase	Interagency Cooperation Activities
NEEDS ASSESSMENT	Include representatives from public and private agencies on the Needs Assessment Team.
	Identify all relevant community agencies and programs.
	Initiate communication with key community agencies, organizations, and groups.
	Review prior community studies and related needs assessment.
	Prepare profiles of selected community agencies that provide services related to the needs of children and families.
	Interview key agency personnel from selected agencies regarding community characteristics, problems, and needs.
	Identify potential interagency linkages.
	Disseminate needs assessment report to community agencies involved in the needs assessment study.
PROGRAM DESIGN	Include selected agency representatives on the Program Design Team.
	Analyze the community in which the program will operate.
	Determine what resources (services, space, personnel, equipment, etc.) are needed from other agencies.
	Specify agencies with which the program will establish interagency linkages.
	Describe the linkages that will be established.
	Design interagency communication strategies.

(Table V-1 Continued)

Program Development Phase	Interagency Cooperation Activities
PROGRAM IMPLEMENTATION	Consolidate interagency linkages.
	Include representatives from other agencies in orientation and inservice training sessions.
	Inform staff of all interagency arrangements.
	Implement interagency arrangements.
	Maintain interagency communication.
PROGRAM MONITORING	Document and assess interagency arrangements (referrals, service coordination, exchange and sharing of resources, meetings, staff).
	Assess impact of interagency arrangements on service delivery objectives.
	Assess impact of interagency arrangements on clients.
	Determine how interagency arrangements can be improved.
	Disseminate monitoring reports to community agencies.

Table V-2

Types of Agencies and Programs	NON-INSTRUCTIONAL PROGRAM COMPONENTS				
	MEDICAL	DENTAL	NUTRITION	PSYCHOLOGICAL	SOCIAL
Welfare Agencies				X	X
Mental Health Clinics				X	X
Foster Care Programs					X
Social Work Agencies				X	X
Day Care Programs					X
Vocational Rehabilitation Agencies				X	X
Hospitals (public & private)	X	X	X		
Clinics	X	X			
Private Practitioners	X	X	X	X	X
Public Health Agencies	X		X		
Drug Abuse Programs	X			X	X
Alcoholism Programs	X			X	X
Legal Services					X
Agencies for the Elderly	X	X	X	X	X
Schools for Handicapped Children	X			X	X
Programs for Battered Wives/Children				X	X
Programs for Child Batterers				X	X
Programs for Wife Batterers				X	X
Youth Organizations				X	X
Colleges & Universities	X	X	X	X	X
Training Institutions/Programs	X	X	X	X	X
Religious Institutions			X	X	X

After the agencies have been identified, the next step is to prepare a comprehensive profile for each key agency. This, too, is done during the needs assessment and is accomplished through questionnaires, interviews with key staff, review of agency reports, and site visits. Agency profiles will enable the Program Design Team to determine what possible types of interagency linkages might be made. The profile should provide a clear understanding of each agency--its mission, the services it provides, its clients, eligibility requirements, its operating procedures, personnel, and resources. It is especially important to determine the fee scale and if the agency has free services or accepts third party payments. Of particular concern is whether an agency shares the philosophy of the non-instructional program, has a similar perception of community needs, and has a commitment to similar goals. An understanding of these factors can help reduce conflicts during program implementation.

STEP B. DEFINE INTERAGENCY LINKAGES

Decisions about specific interagency linkages are made during the program design phase. They are dependent, to a large extent, on the services to be provided and the resources that are needed. After the Program Design Team has decided on the services the program will provide and the resources that will be needed to provide them, it should then begin to consider what services and resources will be needed from other agencies. Examples are outlined in Table V-3, on page 113, which lists various interagency arrangements that might be considered in order to obtain needed services, personnel, space, equipment, training resources, information and ideas, and political and social action.

The Program Design Team must then select the agencies with which it would like to develop interagency linkages and the form the linkages will take. This will be based on the program's needs, the agency profiles developed during the needs assessment, the willingness of other agencies to enter into cooperative agreements, and existing linkages that have been established by the program's sponsoring organization. Funding guidelines may also be a determining factor.

121

Table V-3

Examples of Interagency Cooperation

Types of Resources	Examples of Interagency Cooperation
SERVICES	Referring clients for specific services.
	Arranging to have a service provided by another agency, either at its premises or at the non-instructional program. This might include innoculations, dental work, medical screenings, testing, or treatment.
PERSONNEL	Sharing payment of salaries for specialized personnel such as psychologists, social workers, and nurses.
	Providing field work or internship programs for college students to deliver services, conduct research, or prepare studies and reports.
	"Borrowing" specialized personnel to perform specific functions such as medical screening or testing.
	Obtaining volunteers for specific duties such as escort services.
	Hiring consultants from other agencies to perform specialized functions.
SPACE	Sharing examination rooms, treatment rooms, recreational facilities, meeting rooms, auditoriums.
EQUIPMENT	Sharing major equipment such as computers, word processors, copying machines.

(Table V-3 Continued)

Types of Resources	Examples of Interagency Cooperation
TRAINING	Utilizing staff from other agencies to conduct training workshops. Permitting program staff to participate in training programs provided by other agencies. Utilizing training materials prepared by other agencies. Arranging with colleges to have special credit granting courses developed for program personnel.
INFORMATION & IDEAS	Sponsoring interagency conferences. Sharing needs assessments and special studies. Disseminating program newsletter. Systematic communication through brochures, memoranda, correspondence, fact sheets, etc.
SOCIAL & POLITICAL ACTION	Forming ad hoc or standing committees to work on specific problems. Combining resources for community education efforts. Forming or joining federations for broad based activities.

Interagency cooperation will range from loosely structured, informal linkages to formal contracts. Some linkages, such as federations and coalitions, will be largely administrative. The least formal linkages are those that involve merely the regular sharing of ideas and information through correspondence, newsletters, fact sheets, and reports.

When formal contracts are necessary, the terms should be spelled out in detail. In preparing contracts, your funding guidelines as well as guidelines from your sponsoring organization should be carefully consulted. Formal contractual commitments should cover:

- a thorough description of the services and resources that each party to the agreement will provide
- a clear description of the responsibilities and obligations of each party
- specific limitations or restrictions
- timelines
- staff
- the number of clients and units of service
- costs and fees (and other financial arrangements)

Prior to arranging a meeting with representatives of agencies with which your program desires a formal arrangement, a letter outlining the program's specific needs, the type of interagency arrangement desired, and the purpose or objectives of the arrangement should be sent to the agency director. Any descriptive material about the program that seems appropriate should be enclosed.

The activities described in Step B will take place during the program design phase, although it is likely that some of the formal arrangements will not be consolidated until the start-up period of program implementation.

STEP C. IMPLEMENT AND MAINTAIN INTERAGENCY LINKAGES

Once interagency arrangements are determined, they should be made known to the entire staff. Each staff member should be made aware of how the arrangement affects your program, procedures to be followed, and his or her role. For example, if you have agreed to make referrals to a specific agency for social services, staff should know what person(s) in your program can make referrals, the other agency's eligibility requirements, the person to contact, and what information must be given to the client at the time of referral regarding operating procedures of the other agency. Staff also should be kept up to date regarding any changes in interagency arrangements. This can be done through staff meetings or memoranda.

Maintaining interagency cooperation is time consuming, but it is generally worth the effort. One of the primary requirements is clear and regular communication, which serves several purposes: information sharing, planning, problem-solving, and minimizing conflict or negotiating conflicts that do occur. Different forms of interagency communication, with some advantages and disadvantages, are listed in Table V-4 on page 117. It should be kept in mind that the form as well as the content of the communication should suit the situation.

STEP D. MONITOR INTERAGENCY LINKAGES

Interagency linkages, like all other aspects of the program, should be carefully documented and assessed. All transactions should be recorded. Records of in-person transactions should include dates, persons present, and decisions agreed upon and can be in the form of minutes, memoranda, or letters.

Table V-4

Interagency Communication Methods

Type of Communication	Advantages	Disadvantages
Written		
1. Letters	Can provide a record of interactions. Can be used to explore ideas, options, etc. Can be formal or informal in tone, depending on the situation. Can be used to formalize agreements.	One-way communications; do not allow for immediate clarification of ideas, conflicts.
2. Memoranda	Can provide a record of interactions, negotiations. Can be used for scheduling meetings. Can be used to explain new methods, procedures.	One-way communication.
3. Fact Sheets (brief program descriptions)	Concise; can be reproduced quickly; easily transported.	Require skill in writing important information in a concise form that covers essential facts.
4. Brochures	Provide succinct description of total program. Often serve as initial introduction to program.	May be too bland. Require skill to present relevant information in an attractive and persuasive format that conveys the program's essence.

(Table V-4 Continued)

Type of Communication	Advantages	Disadvantages
5. Annual Reports	Provide historical information about program's goals, objectives, service delivery and management strategies, accomplishments.	Time consuming to prepare and read. May not be read thoroughly. Danger of burying important information.
6. Newsletters	Provide vehicle for sharing current information with selected audiences.	Must be issued regularly. Can become dry and routine.
7. News Releases	Excellent for keeping community up to date regarding important information about program.	Must be clear and informative and written in a manner that will interest newspaper reporters.
8. Special Reports	Provide interim in-depth information on various aspects of program activities or plans. Can be used as basis for staff and interagency meetings, as well as preparation of annual reports.	Time-consuming to prepare and can interfere with ongoing tasks and responsibilities of staff members.
9. Monographs	Provide in-depth information about specific program services and strategies. Especially valuable for researchers and persons interested in replicating the program.	Must be written according to professional standards.
10. Audio-Visuals	Can be dramatic, attention getting, and say a great deal in a brief time. Can be consciousness raising and serve as discussion starter.	Require good A-V production skills. Can be expensive and therefore not always cost-effective.

(Table V-4 Continued)

Type of Communication	Advantages	Disadvantages
In-Person		
11. Telephone	Two-way communication; allows for instant clarification and planning.	Can be time consuming and interrupt other tasks and responsibilities. Sometimes difficult to reach people by phone. Should be well planned so as to cover important items.
12. Office & Site Visits	Two-way communication. Seeing the program in operation provides a stronger impression than merely reading about it and provides a context within which to consider written materials.	Time consuming. One visit does not reveal the entire situation.
13. Group Meetings	Opportunities for group brainstorming, problem-solving, sharing.	Must have effective leadership in order to prevent digression, monopolization, and other barriers to group effectiveness.
14. Informal Meetings	Can develop communication networks that will enhance formal linkages.	Often non-productive.
'5. Conferences	Opportunities for large numbers of participants to cover a wide range of topics in a structured setting.	Require extensive careful planning and follow-up.

The information on interagency cooperation that you will need to gather for the monitoring process should answer the following questions:

- What were the details of the interagency arrangement?
- Did your program and the other agency comply with the terms of your agreement. If not, why?
- What specific problems were encountered and how were they solved?
- What specific services were rendered and to whom?
- How many units of service were involved?
- How many clients were involved?
- What costs were involved?
- What were the effects on clients?
- What were the effects on the non-instructional program?

SUMMARY

The key considerations in designing and maintaining interagency linkages are: a shared program philosophy, complementary program goals and objectives, carefully defined interagency arrangements, a willingness to negotiate differences, and regular and clear communication. If these elements are present, interagency linkages can significantly expand the range and quality of services available to children and their families.

CASE STUDY

ESTABLISHING AND MAINTAINING A SCHOOL-BASED COMPREHENSIVE NON-INSTRUCTIONAL SERVICES PROGRAM

A CASE STUDY

INTRODUCTION

The Follow Through Project in New York City was funded in the 1967-1968 school year. In preparation for the project the city's Board of Education appointed a director who had considerable experience and expertise in supervising early childhood education programs. The director and a small staff initiated the project by examining data on children's school achievement, attendance, and school and community resources. The purpose of this review was to select elementary schools serving economically low-income children where achievement levels and attendance records were unusually low.

The preliminary work involved the Board's Division of Research and Evaluation staff, which had summarized data by districts in each of the city's five boroughs. Since Follow Through was specifically designed to provide innovative instruction and non-instructional services to children who had attended Head Start and other similar preschool programs, the task of identifying potential participant schools was made easy by matching the city's Community Development Agency's data on the location and distribution of Head Start centers with the schools that had the lowest achievement and attendance records.

In a very real sense, this phase--that is, identifying the communities and schools that were the most probable candidates for inclusion in the project--represented a preliminary needs assessment and permitted the Board's Follow Through staff to focus rapidly on the schools and children who could benefit most from the new program.

At the outset, New York City's Follow Through Project consisted of ten elementary schools, located in the poorest sections of the city. While the experimental instructional models at the schools were different, the non-instructional activities were intended to be identical. Moreover, each school was considered a separate functional mini-project within the Board's larger program. According to the Board of Education's organizational plan, a coordinator would be selected for each school. That person would be responsible--with the assistance of the Parent Policy Advisory Committee, central Board, and sponsor staff--for ensuring the implementation of a unique educational experience for children in kindergarten and grades 1-3, and for establishing effective non-instructional services for children and parent involvement programs.

The next step in establishing the project was to recruit and identify the nine coordinators and other staff for Follow Through schools. Position descriptions were written and recruitment was begun through "word of mouth," community media and organizations, major newspapers, and Board of Education publications. Through this process, the Follow Through director, school principals, and parent groups identified, interviewed, and selected coordinators for each of the models. The coordinators then joined the director, principals, and parents in selecting other staff. Finally, the basic staff for each school project consisted of the following personnel:

- Coordinator
- Nurse
- Parent Program Assistant
- Family Assistants
- Family Workers
- Health Aides
- Teachers
- Teachers Aides

The local school districts' early childhood education and health coordinators and board, the Follow Through sponsor staffs, and volunteer parents were also involved in implementing the educational models and non-instructional services at all project schools.

Although each school designed and implemented programs to fit the particular characteristics and needs of its population, the following description of the health (medical, dental and nutrition) components of a non-instructional program is a composite drawn from the data contained in interviews of Follow Through staffs, school principals, and parents. The description begins after some of the staffs at the project schools had been recruited and employed.

NEEDS ASSESSMENT

When the coordinators and some other staff had been hired and received their orientation from the central board's Follow Through director, the school staffs met with the principals and Parent-Teacher Associations to

1. define the role of Follow Through in relation to the total school;
2. determine the specific characteristics of the parent and pupil population;
3. identify the personnel and services available in the schools and districts that would facilitate establishing the project; and
4. list the federal, state, municipal, and private agencies and organizations that should be requested to provide services or to participate in the project in various ways.

When most of these tasks were completed, the program coordinator, often with the assistance of district personnel and volunteer parents, contacted the local public and private agencies, institutions, and service organizations to tell them about the project, find out what services they offered, and enlist their cooperation. These initial

133

contacts were essential to the implementation of the needs assessment phase of the program.

While the project schools has been selected on the basis of objective data that indicated a need for innovative instructional programming for children and assistance for the children's families, that first gross needs assessment lacked the specificity that each project's staff required to establish effective, focused, non-instructional service programs. There were, however, general Follow Through guidelines from the Office of Education which assumed that the most critical immediate needs of the children (outside of effective instruction) were related to their vision, hearing, and attendance. As one early program participant, a nurse, said:

> We had some things from the federal government though, and they were looking for attendance records, visual and hearing screening. I think that was what most of us used as a basis for setting up the program. The idea being that if you can't see, you can't read; if you can't hear, you don't know what the teacher is saying.

Given these basic assumptions, the project staffs began their more particular needs assessment at the beginning of the 1968-1969 school year. They reviewed the Head Start and day care health and medical records of the children in the Follow Through classes to determine how many had medical histories that indicated a need for treatment, how many had been properly immunized, and which families had medical coverage. Various screening programs were then initiated, either at the schools (one had its own dental clinic) or at public and private community health facilities. Across all of the projects, all children were initially given vision, hearing, and dental screenings; some were also given comprehensive physical examinations and were screened for the adequacy of their visual-motor coordination. Further, most project staffs also consulted with parents and classroom teachers about the children's health status. Children who had immeidate critical needs were cared for immediately.

The data from the initial needs assessment identified service delivery priorities for the first year's program and served as the baseline for the staff's efforts in future years.

PROGRAM DESIGN

This phase in the project's development took various forms, depending upon the number of Follow Through classes, the number of project staff, the quality of leadership in each school, the cultural and ethnic affiliation of the families, the characteristics of the communities surrounding the schools, the personal resourcefulness of the project staffs, and the resources available through the districts and the Follow Through director's office. Clearly, the manner in which programs were designed depended upon these factors and on a project staff's level of commitment and the intensity of its vision as agents of positive change in the Follow Through communities. How the project staffs actually handled this phase of their work is instructive.

Each of the plans was different. Yet, since all of the projects had to operate under the leadership of the Follow Through director and were in the same school system, certain planning themes recurred. Some of the problems the staffs wrestled with before full-scale implementation began were:

1. how to coordinate Follow Through non-instructional services with the normal school and district activities and with sponsor requirements
2. the preparation of schedules for continued and expanded health and medical screening for children, with minimal disruptions to their in-class time and school work
3. how and where to expand the cooperative network of hospitals, clinics, and social service agencies to increase the range of services available to children and families
4. the preparation of schedules for the provision of medical and dental care for the children

135

5. how the non-instructional staff would work together, i.e., as a closely coordinated team or individually, but in a complementary fashion

6. how best to utilize the services and expertise of the local district and school health coordinators (all local districts did not have such personnel)

7. what the supplementary nutrition service, i.e., snacks, would consist of

8. what recordkeeping systems would be needed and whether to duplicate existing school records

9. how to develop circular communication systems

10. how to notify parents of apparent or potential health and medical problems and follow-up with the children's families

11. designing medical, dental, and nutrition training programs for teaching staff so that they could then integrate the information into their daily curricula

12. designing workshops on medical and dental care and nutrition for staff, children, and parents

13. developing effective techniques to obtain parent volunteers to assist in the provision of non-instructional services to the children

14. developing appropriate material to communicate information about the projects to the school staffs and cooperating organizations

15. how best to monitor and evaluate the staff's activities and the delivery of services

16. arranging cooperative efforts between projects located near each other

The design of each project's program was facilitated by frequent school and district meetings of staff, principals, parents, the Follow Through director and sponsor staffs to share information and ideas.

PROGRAM IMPLEMENTATION

After all of the children had been screened for vision and hearing, and those with obvious problems had begun to receive care, the non-instructional services staffs, parents, and administrators began to implement the decisions made during their program design meetings.

Typically, subgroups of the staff would meet with the coordinator and the principal to discuss problems and issues and to arrive at particular solutions. Large group meetings were held for the same purpose. The staff also attended meetings regularly at the Board of Education, where they could share information, engage in group problem-solving, and receive assistance and information from the Follow Through director.

Providing primary health care and supplementing the children's diets so that they could attend school every day were the basic goals of the non-instructional services staffs. There were, however, many other problems faced by low-income families that had disruptive effects on their children's schooling, and the project staffs assumed the responsibility for resolving all of them. The staffs assisted families to secure public assistance and supplementary benefits, helped parents to enroll in the medicaid program, counseled parents, and found assistance for siblings of the Follow Through children. All of these activities occurred simultaneously with the annual health screenings, physical examinations, and treatment programs that the staffs devised and implemented for the children.

Because of the central role that health services would play in the provision of non-instructional services, the Follow Through director, school administrators, and parents paid particular attention to the personal and professional characteristics of the nurses and health aides who were recruited to work in the projects. One school principal described the "right kind of nurse" as a person who...

> is based in the community; is able to provide health clinics and workshops; can establish and maintain effective preventive health programs and procedures; and is comfortable in one-to-one conferences with parents and on home-visits.

An example of the critieria for the selection of health aides was that they should have...

> intelligence and patience, no fear of illnesses or handicapped children, the ability to communicate clearly, the capacity to see a problem through from start to finish, the ability to know when problems are serious enough to be referred, good judgment.

In addition to personnel selection and the other critical issues, the Follow Through director, coordinators, and other staff had also to consider space requirements for staff, unusual equipment and supply needs, and the receptivity of the schools' staffs and parents to the projects.

Implicit in each staff member's title and job description was a division of labor. A priority for the Follow Through director and coordinators was to reinforce and strengthen the specific role of each staff member while preserving the integrated service team concept (the service delivery mode chosen by most projects).

Usually the coordinator, social worker, and nurse assumed responsibility for enlarging the number of cooperating organizations and institutions that would provide services to the children and families. The family workers were given the responsibility for collecting daily attendance data and for contacting parents when a child was absent three days. Absences were also reported to the nurse, who contacted parents to determine if children were ill, and if so, whether their medical needs were being met. All staff and parents who volunteered their time and skills to the program were responsible for recordkeeping. When parents used private medical sources for their children they were given forms for their doctors or dentists to complete.

Conducting training workshops and seminars was an additional staff responsibility. The staffs engaged outside speakers on nutrition, dental and medical care, and child development to conduct workshops for themselves, teachers, parents, and the children. Also, Board of Education, sponsor, and project staffs conducted workshops and trained parents. All of the staffs placed a heavy emphasis on training parents to assist in screening children, keeping records, observing children, and researching illnesses. Parents accompanied children to medical facilities; assisted the health aides, family workers, and other staff; and accompanied staff on home visits. Parents with special knowledge and skills also conducted workshops for other parents. The coordinators, nurses, family assistants, social workers, dieticians, doctors, and volunteer parents visited classrooms and participated in instructing children on medical, dental, and nutrition topics. The teaching staffs became more sensitive to the various child and family issues that they could assist with. They integrated medical, dental, and nutrition topics into their curricula; observed the children more closely for signs of illness or malaise; and reported potential problems to the appropriate staff.

As the project staffs gained experience, most of them were able to switch from a purely problem-solving and maintenace approach to a preventive mode. This elaboration necessarily required an expansion of some staff roles. Now the nurses, and in some cases, the teachers, went on home visits; audio-visual materials were obtained; clinics on hypertension, asthma, stress, breast cancer, diet and weight control, first aid, and allergies were held; parents and children were examined for high blood pressure and, when necessary, referred to doctors. The children's near and far vision(rather than the Snellen test only) were tested. The nurses periodically observed the preparation of lunches and checked food quality. The snack program was used more often as an educational tool by introducing the children to new and different foods, followed by discussions in class. At least two projects introduced "strep throat" identification programs for the children, in collaboration with local hospitals. Commerical dental education programs were used in the classrooms. One project made a film of children at the dentist as a demonstration for children who had not had the experience. Another project adopted its sponsor's health curriculum and procedures for measuring the gross effects of the supplementary nutrition program. Recordkeeping became more sophisticated and refined, with the total elimination of duplication and the introduction of medical/dental, height/weight, physical control sheets for each child. Consumer education workshops were held regularly; community and citywide resource files were established for parents; and in order to inform the communities, parents, and cooperating organizations about the projects, newsletters were circulated.

External communication mechanisms were developed that took various forms. During the first year, most of the non-instructional services staffs contributed to weekly or monthly newsletters that were distributed to the children's families, in the communities, to the Board of Education, and to cooperating organizations and institutions. Project workshops, clinics, and health fairs--all of which involved parents, community residents, and professionals--were another form of communication.

In arranging services for the children and their families, the staffs made presentations about the project's services and goals to agencies, organizations, and institutions (e.g., the city's Department of Health, local hospitals, the visiting nurse service, the public health service, Head Start, the Agency for Child Development). Reporters from the city's major publications visited the projects and described them in newspaper articles. For several years the New York State Department of Education provided funding for mini-conferences that involved educators, social service, health, medical and nutrition professionals, parents, community residents, and workers. The state also sponsored annual conferences in Albany, NY, at which the project staffs made presentations about and prepared descriptive displays of their services. Descriptive information about the project's services are included in the National Dissemination Network's publication Education Programs That Work, and through the Network the projects distributed descriptive literature to schools and districts in all of the states.

PROGRAM MONITORING

Monitoring of Follow Through's non-instructional services is concerned with the details of daily, weekly, and monthly activities, including such events as: the frequency with which the staff escorts children to medical and dental facilities, the match between the children's needs and the kinds of services offered, the adequacy of screening procedures, the frequency of staff contacts with parents, whether there are sufficient parent volunteers, the staff's responsiveness to ordinary and emergency situations, the content of the supplementary nutrition program, whether children and parents received medical, dental, and nutrition education. These kinds of information are obtained from three primary sources: the staff's extensive and continuous observations, oral reports, and program records.

In New York City's Follow Through, nurses inspected snacks and observed the preparation of lunches and the children's reactions to particular foods. The nurses kept voluminous records and files on the kinds of emergency help they gave. The staffs requested the results of the tests, examinations, and care the children received from doctors and other medical personnel. Parents who took their children to private physicians were asked to present records for the project's files.

From the very beginning, the staffs recorded the number and categories of health screenings they provided, the number and kinds of follow-up procedures, the number of parent contacts and the reasons for them, the dates of examinations, the number and the reasons for pupil absences, the kinds of workshops and clinics that were held and who participated in them. In all cases, the first year's records were used as the reference points for performance and progress in subsequent years. Moreover, every year schedules were revised, services were expanded, and procedures were changed in response to the changing needs of the children and to improve the range and pace of services.

Through weekly meetings and daily contacts with staffs and parents, program coordinators kept abreast of staff performance and the flow of services. The Follow Through director, sponsor staffs, and district health coordinators also monitored the project's work. They attended staff problem-solving meetings as resource persons and periodically requested lists of unresolved treatment problems, the number and types of screenings completed, the names and addresses of children who still needed care, the kinds of workshops and clinics that had been conducted, and lists of participants. They also inspected samples of health records for accuracy, requested records of the children's current health status, checked the pace of screenings and examinations, suggested more effective procedures, and assisted in designing better recordkeeping systems. At another level, the U.S. Department of Education's Follow Through Division program officers participated in monitoring the non-instructional services staffs' work. They frequently visited the projects to observe the children and the ongoing work and to inspect records. The federal staff and consultant teams interviewed the project staffs, parent volunteers, and adminstrators. The teams also reviewed screening, examination, treatment, and follow-up procedures. At the end of these program reviews, the staffs received immediate feedback on their performances. The program officers also sent summary reports of their findings to the Follow Through director and project coordinators.

Data compiled annually consisted of the number of children screened and the types of screening, the number of parent volunteers and the kind of work they did, the number of workshops and clinics and the number of persons who attended them, the number of home visits, the number of staff observations, the number of snacks served, the number of institutional service contacts developed during the year, the number of medical, dental, and social problems the staff had resolved, the degree of parental satisfaction with the services, and the number of children enrolled in the project classes (which increased annually for almost a decade). At each level (i.e., the U.S. Department of Education Project Office, independent readers for the Department, sponsors, external researchers, the Follow Through director, and district staff) the non-instructional staffs' work was assessed for its adequacy and responsiveness to the needs of the children and parents within the context of the federal Follow Through guidelines. Finally, beginning in 1977, all but one of the projects prepared submissions for the Department of Education's Joint Dissemination Review Panel (JDRP), which validated projects that had achieved consistently successful results with the Follow Through children and families. Although validation was based primarily on the children's academic records, an explicit assumption of Follow Through is that effective non-instructional services contribute significantly to children's academic success. Over a four-year period, all of the projects that submitted data to the panel were validated.

****

If the projects seemed virtual beehives of activities, that impression is accurate, for the examples above are only a small sample of the many creative solutions that non-instructional services staffs devised to enhance the health and well-being of Follow Through children and their families. According to the project participants, the positive effects of the non-instructional services were numerous:

- The physical health of the Follow Through children was dramatically improved and remained so.
- Most participating parents were made more aware of the importance of consistent health care and of the need for proper dietary control for their children.
- The efforts in behalf of the children and their families united the staffs and parents in a unique, close, productive relationship.
- The staffs encouraged a consistently high level of volunteerism among parents, among professionals, and among skilled community members, who--inspired by the enthusiasm and commitment of project personnel and parents--willingly gave their time and skills to the schools for the children's sake.
- Many parents learned information and skills they would not have acquired if they had not had the opportunity to interact with the staffs.
- Many parents gained employment in the schools as non-instructional services staff, and some resumed their formal academic training.
- Teaching staff and other school professionals learned more about the Follow Through families and the communities they served than was ever possible before in a traditional inner-city elementary school environment.
- Finally, the schools and their staffs gained the respect of the families and communities to an unusual degree because of the non-instructional services staff's obvious commitment to the children's welfare.

WORKBOOK

NON-INSTRUCTIONAL PROGRAM DEVELOPMENT

NEEDS ASSESSMENT

PROGRAM MONITORING WORKSHEET #1

INFORMATION NEEDED (by Components) & SOURCE

(See pages 92-96)

INFORMATION NEEDED (by Program Components)	SOURCE (e.g., case records)	TECHNIQUE (e.g., record reviews)

PROGRAM MONITORING WORKSHEET #2

MONITORING SCHEDULE
(See pages 96-97)

REPORTS (describe briefly)	FREQUENCY (e.g., weekly)	STAFF RESPONSIBLE	AUDIENCE

PROGRAM MONITORING
CHECKLIST

1. The person(s) responsible for designing the monitoring system are thoroughly familiar with the contract, the program design, and the implementation schedule. ______
2. The general information needs have been clearly determined. ______
3. Information needs of specific audiences have been given consideration. ______
4. Sources of monitoring information have been identified. ______
5. Information collection techniques have been selected and instruments designed where necessary. ______
6. A monitoring schedule has been prepared that includes the type of information to be collected and the reporting deadlines, and also identifies the staff responsible for data collection and report writing. ______
7. The staff has been trained to (a) use the monitoring system and (b) understand its programmatic value. ______
8. Management and service delivery staff recognize that a primary purpose of monitoring is to provide information that can be used to improve the program; that is, serve as an ongoing needs assessment and be used in program design. ______
9. The monitoring process is continually reviewed to ascertain whether it is achieving its purpose in a cost-effective manner. ______

NEEDS ASSESSMENT WORKSHEET #1

MEMBERS OF THE NEEDS ASSESSMENT TEAM

NAME	ADDRESS/TELEPHONE

NEEDS ASSESSMENT WORKSHEET #2

NEEDS ASSESSMENT TEAM PROFILE

On the left is a list of categories of individuals (e.g., school administrator) and types of skills (e.g., research) that should be included on the Needs Assessment Team. Across the top is space for names of team members. Put an "X" for each person's attributes.

	NAMES											
CATEGORIES												
School Administrator												
PAC Member												
Teacher												
Community Ag. Rep.												
Community Leader												
College Faculty												
Other												
SKILLS/INFO												
Research												
Program Planning												
Group Leadership												
Knowledge of Data Sources												
Community Contacts												
Budgeting/Financial												
Fundraising												
Program Implementation												
Writing/Editing												
Publicity												
Other												

NEEDS ASSESSMENT WORKSHEET #3

RESPONSIBILITIES & TIME SCHEDULE

TASKS	PERSONS(S) RESPONSIBLE	COMPLETION DATE
Coordinate Needs Assessment Process		
Prepare NA Budget		
Review Related Studies		
Specify Information to Be Collected		
Identify Data Sources		
Select Data Collection Methods		
Prepare Data Collection Methods		
Prepare List of Community Agencies		
Identify Key Community Agencies		
Develop Liaisons with Community Agencies		
Train Personnel to Conduct Research		
Supervise Data Collection		
Collect Data		
Analyze Data		
Determine Priorities		
Write Report		
Disseminate Report		

NEEDS ASSESSMENT WORKSHEET #4

OVERVIEW

1. Scope of Needs Assessment

2. Time Frame: Begin ______________ Complete ______________

3. Budget

4. Personnel (in addition to Needs Assessment Team) to Collect and Analyze Information, etc.

Personnel	Responsibilities

NEEDS ASSESSMENT WORKSHEET #5

COMMUNITY RESOURCES & BARRIERS

1. Resources (factors that will help)

2. Barriers (factors that will hinder)

NEEDS ASSESSMENT WORKSHEET #6

SOURCES OF DATA

(See pages 21-30)

SOURCES (Institutions, Agencies, Individuals)	TYPE OF INFORMATION (Demographic, Services, Family Status, etc.)	COLLECTION METHODS (Interviews, Surveys, Questionnaires, etc.)

NEEDS ASSESSMENT WORKSHEET #7

PROBLEM DESCRIPTION

(See pages 31-32)

Complete for each significant problem that is identified.

1. Extent/Severity of Problem

2. Influencing Factors

3. Resources Available

4. Needed Resources/Services

NEEDS ASSESSMENT WORKSHEET #8

AGENCY PROFILE

Name of Agency ______________________________

Address ______________________________

Contact Person ____________________ Phone No. ______________

Services offered, target population, number of clients (by age, sex, etc.):

Services	Target Population	No. of Clients

Staff:

Job Titles	Number	Fulltime or Parttime

AGENCY PROFILE - page 2.

Budget: Current Fiscal Year ______________

Prior Fiscal Year ________________

Catchment Area ____

Eligibility Requirements ______________________________________

____

____

____

____

Fees (amount, fixed, sliding, third-party payments):

Hours of Service:

Is an appointment necessary? Yes ___ No ___

Is there bilingual staff? Yes ___ No ___

If yes, what languages in addition to English are spoken?

Additional Information:

NEEDS ASSESSMENT CHECKLIST

1. The Needs Assessment Team is representative of the community and includes representatives of the school or the sponsoring organization to ensure that its views and needs are included from the inception of the program. ____
2. Team members have the necessary information and skills to effectively plan and oversee the needs assessment process. ____
3. The Team has secured the necessary outside expertise for the execution of the needs assessment--such as researchers, statisticians, interviewers, computer programmers, writers/editors. ____
4. The Team members are knowledgeable about their roles and responsibilities and the purpose of the needs assessment. ____
5. The financial resources necessary for conducting the needs assessment are available. ____
6. The scope of the needs assessment has been clearly defined. ____
7. The type of information needed has been clearly defined. ____
8. The method of data analysis has been determined. ____
9. A time frame has been established. ____
10. The sources of information have been identified. ____
11. The information-gathering methods have been selected. ____
12. The necessary instruments have been designed. ____
13. A method for determining priorities has been established. ____
14. Individuals to whom the needs assessment report will be disseminated have been decided upon. ____

PROGRAM DESIGN

PROGRAM DESIGN WORKSHEET #1

MEMBERS OF PROGRAM DESIGN TEAM

NAME	ADDRESS/TELEPHONE

PROGRAM DESIGN WORKSHEET #2

PROGRAM DESIGN TEAM PROFILE

On the left is a list of categories of individuals and types of skills that should be included on the Program Design Team. Across the top is space for names of team members. Put an "X" for each person's attributes.

	NAMES											
CATEGORIES												
School Administrator												
PAC Member												
Parent												
Teacher												
Community Ag. Rep.												
Community Leader												
College Faculty												
Other												
SKILLS/INFO												
Program Planning												
Group Leadership												
Knowledge of Community Services												
Program Administration												
Service Delivery												
Legal												
Budgeting/Financial												
Fundraising												
Staff Development												
Other												

PROGRAM DESIGN WORKSHEET #3

PROGRAM'S CONCEPTUAL BASIS, PHILOSOPHY, GLOBAL GOAL(S)
(See pages 43-44)

1. Statement of Conceptual Basis

2. Statement of Philosophy

3. Statement of Global Goals)

PROGRAM DESIGN WORKSHEET #4

GOALS & SERVICE OPTIONS FOR EACH PROGRAM COMPONENT
(See pages 45-48)

COMPONENT (e.g., medical)	COMPONENT'S GOALS	SERVICE OPTIONS FOR EACH GOAL

PROGRAM DESIGN WORKSHEET #5

PROGRAM SERVICES

COMPONENT (e.g., dental)	SERVICES TO BE PROVIDED

PROGRAM DESIGN WORKSHEET #6

RESOURCES NEEDED

(See pages 54-55)

For each service, prepare a list of resources that will be needed.

Program Component ______________________________

Program Service ______________________________

1. HUMAN RESOURCES (staff, volunteers, etc.)

2. MATERIAL RESOURCES (supplies, equipment, materials, etc.)

3. FINANCIAL RESOURCES (budget allocation)

4. ENVIRONMENTAL RESOURCES (space, furnishings, etc.)

PROGRAM DESIGN WORKSHEET #7

PERSONNEL NEEDS

(See pages 55-56)

Based on the human resources needed for each service (worksheets #6), prepare a list of personnel needed for the program. This list can then be used as the basis for more detailed job descriptions.

JOB TITLE & NO.	PROFESSIONAL REQUIREMENTS	OVERALL RESPONSIBILITY	REPORTS TO

PROGRAM DESIGN
CHECKLIST

1. The Program Design Team includes persons who were involved in the needs assessment as well as persons who will be responsible for program implementation. ____
2. Team members are knowledgeable about their specific roles, responsibilities, and the overall purpose of the Program Design Team. ____
3. Team members are thoroughly familiar with the needs assessment report. ____
4. A time frame has been clearly established. ____
5. The program's mission is clearly defined. ____
6. Goals for each program component have been established. ____
7. Specific services to be delivered have been delineated and their objectives clearly stated. ____
8. The service delivery schedule has been prepared. ____
9. The design of the service delivery schedule takes into consideration the instructional needs of the children, accessibility of services, the attitudes and preferences of teachers, and the needs of parents. ____
10. The service delivery process (i.e., outreach, intake, client assessment, and service provision) is clearly spelled out. ____
11. The format and maintenance procedures for client case records have been established and assure client confidentiality. ____
12. Eligibility criteria have been established. ____
13. Management resources necessary for program implementation (i.e., budget, personnel, space, equipment and supplies, program materials, etc.) have been specified. ____
14. An organizational chart and job descriptions have been prepared. ____
15. A well integrated program information system has been designed that clearly spells out content, frequency, and dissemination of reports as well as staff responsibilities. ____
16. The information system reflects the needs of those who will maintain the system as well as those who will use the information. ____
17. Interagency linkages have been identified and described. ____
18. Orientation and inservice training models have been outlined. ____

PROGRAM IMPLEMENTATION

PROGRAM IMPLEMENTATION WORKSHEET #1

STAFF RECRUITMENT

(See page 78)

Recruitment sources include, but are not limited to, sponsoring organization, parents, newspapers, public and private employment agencies, personal contacts, professional associations.

JOB TITLE (list each job title & no. of positions)	RECRUITMENT SOURCES

PROGRAM IMPLEMENTATION WORKSHEET #2

CANDIDATE PROFILE
(Attach to Resume or Application Form)

Date of Interview________________

Name of Candidate____

Address____

Telephone____

Position Applying for____

Learned About Position from____

Person(s) Conducting Interview____

____

Comments____

____

____

____

____

Disposition: Hire_______ Not Hire______

Recommend Another Interview_______

Keep in Active File_______________

Refer to Another Agency__________

Other____

____

____

____

____

PROGRAM IMPLEMENTATION WORKSHEET #3

SERVICE DELIVERY PLAN

(See page 77)

TIME FRAME	SERVICES (Title; Participants; Activities)	STAFF MEMBER(S) RESPONSIBLE

PROGRAM IMPLEMENTATION WORKSHEET #4

ORIENTATION PLAN

(See page 68)

1. Content to Be Covered in Orientation Session

2. Staff Responsible for Conducting Orientation & Function

Staff	Function

3. Schedule of Orientation Activities

PROGRAM IMPLEMENTATION WORKSHEET #5

INSERVICE TRAINING PLAN
(See pages 68-69)

WORKSHOPS & DATES	PARTICIPANTS	WORKSHOP LEADER(S)

PROGRAM IMPLEMENTATION WORKSHEET #6

ORGANIZATION CHART

(See page 60)

PROGRAM IMPLEMENTATION WORKSHEET #7

IMPLEMENTATION SCHEDULE

(See page 79-80)

PRE-OPERATIONAL & START-UP TASKS	MONTHS											
o Select Staff - recruit - screen - interview - select - hire												
o Refine & Integrate Management and Service Delivery Systems a. review the proposal and contract b. establish procedures for coordinating and integrating management and service delivery systems c. specify staff roles and to whom they report d. refine service delivery forms e. refine management forms f. refine monitoring forms												
o Initiate Fiscal & Budgetary Processes a. analyze budget; make quarterly expenditure estimates and projections b. open bank account c. install bookkeeping, payroll, inventory and voucher systems												

PROGRAM IMPLEMENTATION WORKSHEET #7

PRE-OPERATIONAL & START-UP TASKS (Cont.)	MONTHS											
d. institute appropriate internal budgetary controls e. institute financial data collection process for monthly financial planning and statements												
o Conduct Orientation o Train staff in use of monitoring system o Clarify and consolidate interagency linkages												
ON-GOING ACTIVITIES												
o Deliver services (List each service seperately) o Monitor program o Prepare reports (List reports to be prepared on a weekly, monthly, quarterly, semi-annually, and annual basis) o Conduct inservice training o Hold staff conferences												

PROGRAM IMPLEMENTATION CHECKLIST*

1. The program design has been reviewed and has been revised where necessary. ____
2. The implementation schedule has been developed. ____
3. There is a full complement of staff with adequate competencies to carry out the work of the program. ____
4. Staff understand and are committed to the program's mission. ____
5. Staff are clear about service objectives. ____
6. Staff members understand their individual responsibilities and tasks. ____
7. Staff members have an understanding of the responsibilities and tasks of their co-workers. ____
8. Staff understand the management system. ____
9. Staff understand the service delivery system. ____
10. Staff understand the monitoring system. ____
11. Volunteers are being recruited. ____
12. The program information system has been designed. ____
13. Policies and procedures for interagency cooperation and linkages have been established and formal agreements have been finalized. ____
14. Descriptive and operational materials have been developed. ____
15. Physical resources (i.e., space, materials, and equipment) have been obtained and prepared. ____

*This checklist should be used at the end of the start-up period to make certain that all elements are in place for ongoing operation. It is to be expected that some activities designated as part of start-up will have to be delayed. However, the majority should be taken care of before ongoing operation actually begins.

PROGRAM MONITORING

PROGRAM MONITORING WORKSHEET #1

INFORMATION NEEDED (by Components) & SOURCE
(See pages 92-96)

INFORMATION NEEDED (by Program Components)	SOURCE (e.g., case records)	TECHNIQUE (e.g., record reviews)

PROGRAM MONITORING WORKSHEET #2

MONITORING SCHEDULE
(See pages 96-97)

REPORTS (describe briefly)	FREQUENCY (e.g., weekly)	STAFF RESPONSIBLE	AUDIENCE

PROGRAM MONITORING
CHECKLIST

1. The person(s) responsible for designing the monitoring system are thoroughly familiar with the contract, the program design, and the implementation schedule. ____
2. The general information needs have been clearly determined. ____
3. Information needs of specific audiences have been given consideration. ____
4. Sources of monitoring information have been identified. ____
5. Information collection techniques have been selected and instruments designed where necessary. ____
6. A monitoring schedule has been prepared that includes the type of information to be collected and the reporting deadlines, and also identifies the staff responsible for data collection and report writing. ____
7. The staff has been trained to (a) use the monitoring system and (b) understand its programmatic value. ____
8. Management and service delivery staff recognize that a primary purpose of monitoring is to provide information that can be used to improve the program; that is, serve as an ongoing needs assessment and be used in program design. ____
9. The monitoring process is continually reviewed to ascertain whether it is achieving its purpose in a cost-effective manner. ____

INTERAGENCY COOPERATION

INTERAGENCY WORKSHEET #1

NON-INSTRUCTIONAL
PROGRAM COMPONENTS

AGENCY LINKAGES
(See page 111)

AGENCIES/PROGRAMS

AGENCY	Medical	Dental	Nutrition	Psychological	Social	TYPE OF LINKAGE

INTERAGENCY WORKSHEET #2

INTERAGENCY AGREEMENT
(See pages 112-115)

Between:

______________________ and ______________________
(Agency Z) (Agency Q)

To provide: ______________________

It is hereby agreed that AGENCY Z will: ______________________

AGENCY Q, in exchange for the above, will: ______________________

Description Specific Service	Dates From - To	Staff Persons Responsible	Cost

Special Provisions: ______________________

Authorized Signatures:

______________________ ______________________
(Agency Z) (Agency Q)

INTERAGENCY COOPERATION
CHECKLIST

1. A list with descriptions of relevant agencies has been prepared or is available from another source. ____
2. A comprehensive profile of each key agency has been prepared. ____
3. Agencies to be considered for various types of interagency agreements have been identified and initial contacts made. ____
4. Specific features of interagency linkages have been defined. ____
5. Interagency linkages have been consolidated with letters of agreement, etc. ____
6. The staff has been informed of the details of each interagency agreement. ____
7. Techniques have been established for keeping staff up-to-date regarding changes in interagency arrangements. ____
8. Different forms of interagency communication have been designated and staff responsibility delegated. ____

ANNOTATED BIBLIOGRAPHY

Introduction

The annotated bibliography[1] provided here is designed to assist planners concerned with establishing comprehensive, non-instructional services in an educational setting. The majority of the articles referenced in this bibliography describe specific interventions involving one or more non-instructional services. Other articles provide resources/tools that are helpful in designing or operating such interventions, or provide background information useful for program planning in this area. The specific non-instructional services targeted in the bibliography include psychological servcies, social services, and health services (i.e., general, nutrition, dental, and medical).

The articles are organized into four sections as follows:

- General Overview
- Needs Assessment
- Service Delivery (includes Program Design and Implementation)
    - A. Comprehensive Services
    - B. Health Services
    - C. Psychological Services
    - D. Social Services
- Evaluation/Monitoring

This organization parallels the outline in the manual, A Guide for Designing, Implementing, and Monitoring Non-Instructional Educational Services; in this way, the bibliography can be used as a companion resource with the planning and management guide.

---

[1] It should be noted that citations from international publications and doctoral dissertations do not include an abstract; the author, title, and source are provided for the reader's reference.

GENERAL OVERVIEW

Abstracts of Midwest Center/Satellites final program reports. Washington, D.C.: Office of Education (DHEW), 1976.

This document is a collection of six abstracts representing a summary of the activities of a three-year project supported by the Education Professions Development Act. Addresses are included for copies of specific final reports. Satellite projects were implemented, based in Chicago, Indiana, Louisville, Kentucky, Ohio, Urbana, Illinois, and the Midwest Center, Indiana. Each abstract describes a specific project to improve the quality of pupil personnel services for inner city high schools; to increase communications between school personnel and the university education staff; and to develop, integrate and sustain systems whereby school personnel, university staff, and community sources would plan together and be involved in the improvement of the inner city schools.

Barbacovi, D. *et al*. *The Handicapped Children Act, P.L. 94-142: Implications for principals*. Paper presented at the National Association of Secondary School Principals Annual Convention, New Orleans, January, 1977.

Provided is a frame of reference for considering the potential impact of Public Law 94-142, the Education for All Handicapped Children Act, on school administrators. It is explained that Public Law 94-142 may reshape three traditional aspects of existing school environments: first, it might be anticipated that the underlying approaches used to accomplish the mission of schools may change; second, the role relationships between and among educational professionals, social service professionals, parents, and students may change; and third, changes in the rationale and processes of educational decision making may occur. Due process and procedural safeguards, individualized educational programs, and the concept of least restrictive environment are also considered.

Des Jardins, C., & Hull, R. *Rights Handbook for Handicapped Children and adults*. Chicago: Co-ordinating Council for Handicapped Children, 1977.

The handbook is intended as a reference to rights of handicapped children and adults as defined by federal and state legislation. A section on education makes up a major portion of the document and includes information on the following areas: definition of handicapped children, early childhood, visual impairment, hearing impairment, physical or health impairment, learning disability, educational handicap, emotional handicap, behavior disorder, mental impairment, speech and/or language impairment, multiple impairment, home and hospital, prevocational, special education supportive services, psychological services, social work services, special education summer programs, services for children in their primary language, mainstreaming, termination of special education placement, graduation of handicapped students, exclusion of handicapped students, state-operated or private program, impartial due process hearing, parents' rights to inspect children's records. Special education services for children in residential care, transportation of handicapped children, and five basic steps in enrolling a handicapped child. Other sections cover the Illinois individual care grant program, supplemental security income, social security income, tax deductions, rights of institutionalized persons, developmental disabilities, vocational rehabiliation, employment, housing, transportation, architectural barriers, civil rights, and other rights.

A final program report from the University of Illinois, Chicago Circle and Chicago public schools, 1971-74. Washington, D.C.: Office of Education (DHEW), 1974.

The Chicago Satellite, as a member of the EPDA Midwest Center Consortium, sought to create the EPDS's "new professional" by retraining in-service teachers and school staff. The University of Illinois at Chicago Circle's College of Education and the Department of Educational Psychology at the Urbana campus are working in conjunction with Chicago School District #9 and the Midwest Center at Indiana University to develop and test a model aimed at improving the educational atmosphere of a large inner city high school. A collaborative project was conceived wherein the universities, school district, and community get together to find new ways of cooperative planning which would produce classrooms and curricula that would meet the needs of their students. The model employed attempts to train a new professional able to serve the student client as well as the system client. The major objectives were: (1) development of new degree programs at the university level, (2) development of experimental pilot courses which could identify and teach newly needed skills, and (3) development of courses related to the practical problems of inner city schools. A second set of objectives included organizational development, staff development, and program development. The fully-developed program was shown to have considerable impact.

Garner, C.W. A comprehensive instructional package for the disadvantaged. Paper presented at the State Convention of the Vocational Education Association of New Jersey, Great Gorge, N.J., April 2-3, 1981.

The educational deficiencies of disadvantaged secondary students can be realistically overcome through a comprehensive program.

First, the educational package must include an individualized educational plan that focuses on resolving each student's specific difficulties. Second, the package must include a mastery-based instructional program. The mastery learning model of teaching is essential in order for a teacher to reach all the students in a course. Finally, the package must include a set of student services including work experience, job planning, career counseling, personal counseling, physical evaluations, and parental counseling.

Ludvigson, G. (Ed.). A pupil services model for the state of Wisconsin: A fresh approach. Washington, D.C.: Office of Education (DHEW), 1978.

The nature and functions of pupil personnel services staff, together with a model of a typical pupil personnel services organization found effective in the public schools of Wisconsin, are presented. Salient features of the recommended model include: (1) services for all children; (2) direct line responsibility to the district administrators; (3) a basic core of pupil personnel services discipline; and (4) the flexibility to accommodate local needs. The appendices contain examples of proposed pupil personnel services administrator certification, position descriptions, and organizational charts.

Maher, C.A. Systems thinking for pupil personnel services. Journal of the International Association of Pupil Personnel Workers, March 1979, 23(2), 97-102.

Discusses systems theory and concepts in relation to pupil personnel services. Systems thinking can provide a framework for pupil personnel managers to: (1) conceptualize their department as a system; (2) assess the performance of the department; and (3) coordinate the problem-solving activity of pupil personnel practitioners.

Menolascino, F.J. Handicapped children and youth: Current-future international perspectives and challenges. Exceptional Children, November 1979, 46(3), 168-73.

Current and emerging trends that impact upon special education worldwide are reviewed. These trends focus on prevention and research, normalization, community-based service systems, parental rights, consumer advocacy, home training, curative approaches, and cost/service benefits. Coalitions of professional organizations are suggested as a means of meeting the challenge of international issues that face those individuals and communities involved in providing services to handicapped and gifted children.

Pupil personnel services in California public schools: Needs, problems, and a plan for solutions. Sacramento, Calif.: Bureau of Pupil Personnel Services, California State Department of Education, 1975.

The Guidance and Counseling Task Force of the California State Department of Education was charged with the task of studying the pupil personnel services available to students in California schools and of developing a plan for improving and extending those services where needed. This document is the result of more than a year of study and direct consultation with hundreds of professional and lay persons and includes their subsequent reactions to a first of a proposed plan completed in July 1973. It presents the results of the most comprehensive study of pupil personnel services ever conducted in California and the means of improving those services. Members of school district governing boards, superintendents of schools, principals, pupil personnel specialists, and concerned citizens will find in this publication significant proposals for improvement that should be useful. The four major subjects dealt with in this publication are the following: (1) results of a statewide assessment of the needs and problems of individuals and society in relation to pupil personnel services; (2) plan of the State Department of Education for improving pupil personnel services in California; (3) development of plans for improving pupil personnel services provided by offices of county superintendents of schools and school districts; and (4) promising practices and programs in California schools related to satisfying identified individual and societal needs through pupil personnel services.

The Rehabilitation Act: An analysis of the Section 504 regulation and its implications for state and local education agencies. Washington, D.C.: National Association of State Directors of Special Education, 1977.

Presented is an overview of the Section 504 regulations of the 1973 Rehabilitation Act, with section by section analysis of the implications of these regulations for state and local education agencies serving handicapped students. Final rules and regulations along with corresponding implications are provided in six sections (sample subtopics are in parentheses): general provisions (definitions, discrimination prohibited, and assurances); employment practices; program accessibility (existing facilities and new construction); preschool, elementary, and secondary education (application, free appropriate public education, and procedural safeguards); postsecondary education; and health, welfare, and social services.

Working with the handicapped: The counselor and the visiting teacher. Austin, Tex.: Texas Education Agency, 1978.

Counselors and visiting teachers serving special education students face unique problems in meeting the needs of those students. The general and specific knowledge that the counselors and visiting teachers should have in order to work most effectively with students with special needs has been the focus of a study sponsored by the Texas Education Agency. The study seeks to define the roles and to identify the competencies, both shared and unique, of counselors and visiting teachers who serve exceptional children and their families. Topics discussed are: planning and evaluation, pupil appraisal, instructional delivery, special supportive services, parent counseling and involvement, coordination and utilization of community resources, inservice education, and guidance and counseling.

NEEDS ASSESSMENT

Barnes, K.D. The state of urban school guidance and counseling in the major school districts of America. Washington, D.C.: Office of Education (DHEW), 1980.

A comprehensive analysis of the state of school guidance and counseling emphasizing career guidance and counseling involved a literature search, compilation of current educational statistical data, a national survey of large city career counseling services, visitations and direct communication with school guidance personnel, and interviews with leaders in the field. Factors in the home, school, and community which influence urban youth were identified. Reform of past practices emphasizing special needs and college-attendance-related job functions was recommended to respond to the varied services demanded from and limited funds available to counselors today. Although they are sound, existing models for delivery of career counseling were considered dependent on accurate student needs and self-understanding information. An alternate method incorporating community involvement was suggested. A survey of the 112 largest public school systems produced information indicating that career guidance and counseling services in urban schools (1) are not properly funded; (2) lack adequate supplies, resources, and personnel; (3) need to develop models to improve services; (4) need to establish operational professional roles and function statements; (5) are facing pressure to add more duties despite staff shortages; (6) require more intensive inservice training and skill development experiences; and (7) must improve their communication skills with school staff and the community.

Evans, P.L. A model for conducting needs assessments and a report on national ratios. Paper presented at the Annual Convention of the American Psychological Association, New York, September 1, 1979.

The opinions of 162 psychologists, 842 teachers, 125 public school administrators and 50 state departments of education were surveyed regarding the current status of service delivery and school psychology. The first questionnaire was directed to coordinators of school psychological services and school psychologists and requested information about the academic background and training of the school psychologists. A second questionnaire, disseminated by school psychologists to teachers and public school administrators, queried respondents on which services psychologists performed that they felt were most helpful in the public schools. A third questionnaire, mailed to practicing psychologists, involved rating of specific tasks according to the relative importance of the task to respondents' positions. Among findings was that the most frequent recommendation of public school administrators, school psychologists, and classroom teachers for improving psychological services in the schools is that of reducing the current ratio of psychologists per pupil. Statistical data and sample questionnaires conclude the document.

Lamb, M.L. A needs assessment of the public schools in the thirty-one southernmost counties in Illinois. Springfield, Ill.: Illinois State Office of Education, 1977.

In May of 1977, each public school district and regional superintendent in the 31 southernmost counties of Illinois (principally rural, small schools) was sent a number of the needs assessment instruments. The 295 returned instruments included responses from the following elementary and secondary personnel: teachers (N=86); principals (N=85); guidance counselors (N=40); superintendents (N=70); and other specialists (N=14). The instrument provided data regarding: respondents' county; years of experience; school district type (elementary, high school, or unit district); total school enrollment (below 250 to above 2,000); administrative needs; curriculum needs; instructional needs; and pupil personnel services and adult education needs. Major findings indicated: the five most significant needs were increasing pupil motivation, developing favorable pupil attitudes toward learning, maintaining effective school/community relations, improving articulation and continuity in curriculum organization, and understanding evolving state legislation related to schools; as a group, the administrative needs were the most pressing; and only in the area of job classification was there respondent disagreement among problem areas (district size, type of district, or years of experience having had no significant bearing on respondent responses).

Needs assessment: Pupil personnel services. Springfield, Ill.: Illinois State Board of Education, 1981.

This survey was conducted based on requests from local education agencies who wish to use models in creating their own needs assessment. The 39 sample forms and questionnaires included in this document represent pupil personnel services which are delivered through a variety of educational systems. The Illinois State Board of Education cannot endorse any of the instruments; they are being provided strictly as resource material. Priorities in programming should develop from identified needs of students, staff, administrators, and parents, ordered according to rational and defensible criteria. Decisions relating to what services are offered, who provides them, how they are delivered, and for whom they are designed should be based on objective data, systematically obtained. The following steps suggest basic guidelines for conducting a systematic needs assessment: (1) organize a planning group; (2) identify goals and the target group(s) to be surveyed; (3) determine the methodology to be used; (4) decide on follow-up procedures to be used if initial response rate is inadequate; (5) develop procedures for summarizing and interpreting needs assessment results; (6) plan how and to whom results should be disseminated; and (7) determine how needs assessment data are to be translated into programmatic goals and objectives.

Wirth-Melliand, L. Single but equal: One parent partnerships with the schools. Updating School Board Policies, June 1980, 11(6), 1-5.

Suggests that school districts survey one-parent families to see what special services they think are needed in the schools. Lists the special services most requested and sources districts can consult for information.

SERVICE DELIVERY

Comprehensive Services

Annual report of the Texas child migrant program, ESEA, Title I, 1974. Washington, D.C.: Division of Compensatory Education, Bureau of Elementary and Secondary Education (DHEW/OE), 1974.

Instructional programs, pupil services, program personnel, and the summer migrant program and institute were described in this annual report. Programs were operated in grades K-12 (with a special preschool for 4-year-olds), serving 59,417 migrant children in 177 Texas school districts during the 1973-74 school year. Affording pupils comparable instructional hours, 16 school districts operated on a state funded extended day 7-month school year, an alternative designed to meet the special needs of migrant children. Enrichment programs included one or a combination of the following plans: extra daily services to provide supplementary instruction, utilizing a resource teacher in the classroom, a circulating supplementary teacher, or teacher aides; an extended day program, providing additional instruction after school; or self-contained classrooms (nongraded migrant pupils only). Program objectives were to provide social services, clothing, transportation, fees, guidance, counseling, psychological services, dental and medical services, and food, as well as instructional activities focusing on reading, oral language development enrichment experiences, English language arts, and mathematics. General conclusions were that the reading ability of migrant students is improving and that some students (48 percent) are showing gains in mathematics.

Arends, R.I., & Arends, J.H. Systems change strategies for the helping professional. Washington, D.C.: National Institute of Education (DHEW), 1976.

This monograph concentrates on the processes of change in a specific social system, the school, and presents specific strategies for promoting system change. It is addressed to school psychologists, counselors, social workers, and pupil personnel workers. The monograph, divided into five chapters, describes both the theoretical and practical aspects of producing system change. In the first chapter the authors describe why schools need to change, and suggest the part that those who provide guidance and pupil personnel services can play. The second chapter explains schools as social systems and describes some group processes through which work is accomplished in schools. Examples and tools appear in the third chapter, while the fourth chapter presents guidelines for facilitating change. The authors suggest trends for the future in the final chapter, and conclude with an annotated bibliography for further reading.

Bercier, B. *1976-1977 final report and evaluation, Title IV project, Independent School District #12 (Blaine, Minnesota)*. Washington, D.C.: Office of Indian Education, Office of Education (DHEW), 1977.

Objectives of the Title IV Indian Education Program were designed to meet the educational needs of the Native American students within the public school as defined by federal program regulations. During the 1976-77 school year, the parent committee hired a home/school coordinator, the only staff position in the program. The coordinator was to identify Native American students within the school district and to provide such services as personal, academic, and crisis counseling, family referrals, long-term personal problem solving, and making student contacts. Program activities were directed around socially and culturally oriented activities from which students would benefit. To evaluate the program, a questionnaire was given to teachers, students, parents, and administrative personnel. The school administration and teachers were very supportive toward the Native American students and problems they faced in school and the community by working closely with the home/school coordinator when difficulties arose. This in itself showed progress and an important function of Title IV in the school system. It was determined that the program had successfully completed its third year of operation. This report summarizes the activities and involvement of the coordinator, and the program activities for the students and for the parent parent committee members; gives brief examples of the types of service provided by the coordinator; and gives a tally count of the responses to 10 statements covering the program's general objectives along with the questionnaire.

Bilingual supportive learning child service demonstration center. *Directory of model programs for handicapped children, 1978-79*. Andover, Mass.: The NETWORK, Inc., 1979.

The Bilingual Supportive Learning Center is a project of the Puerto Rican Family Institute, a bilingual, bicultural agency that provides comprehensive social services to Hispanic families in New York City. The project offers a bilingual LD program to first and second graders who attend three schools in community school district #4, which serves the Upper East Side section of Manhattan, commonly known as Spanish Harlem or El Barrio. The LD resource rooms supplement the bilingual programs already established in each school. Target children now receive indirect service by an LD consultant who works with the classroom teacher. The CSDC staff has translated screening tests and diagnostic instruments into Spanish, and has developed other assessment instruments for use with young bilingual Hispanic children. The project is actively working with parents of target children to make them aware of their children's learning problems, legislation, rights, and community resources.

Carey, R. Trends in counseling and student services. *NASSP Bulleting*, September 1977, *61*(410), 3-10.

The article surveys the broad range of existing programs and notes the implications for administrators.

Fraser, B.C. Integration. *Child Care, Health and Development*, May/June 1977, *3*(3), 201-211.

Analyzed are problems involved in mainstreaming handicapped children. Factors in the child (including social adaptation and adjustment), and external factors (medical services, family support, and educational services) affecting integration are examined.

Hidden handicaps. Del Mar, Calif.: McGraw Hill Films, 1977. (Film)

The film acquaints the viewer with ways in which learning disabled (LD) children are helped through special education and other medical and psychological services; the value of parent groups in helping families with LD children; the controversial treatments which exist; and the concept that learning disabilities are specific, arising from individual discrepancies in a child's development.

Hohenshil, T.H., & Humes, C.W., II. Roles of counseling in ensuring the rights of the handicapped. *Personnel and Guidance Journal*, December 1979, *58*(4), 221-27.

The article provides a description of the legal rights of the handicapped as defined by such legislation as the Rehabilitation Act of 1973 and Public Law 94-142 (The Education for All Handicapped Children Act). Rights are discussed, including the right to education, employment opportunities, health care, and welfare and social services. The following five critical roles of counseling are reviewed: information dissemination, advocacy, parent/family consultation and counseling, participation in writing the individualized education program, and participation in career development programs.

Human services go to school. *Innovations*, Summer 1979, *6*(2), 16-19.

A program is described which involves an interdisciplinary crisis counseling team in a high school to provide human services for students with behavior, emotional, academic, and family problems. Team members are seen to include school counselors, social workers from the Department of Social Services, probation officers, police, a psychiatrist, and home-school liaison consultants.

Love, H.D., & Walthall, J.E. A handbook of medical, educational, and psychological information for teachers of physically handicapped children. Springfield, Ill.: Charles C. Thomas, 1977.

The text is designed to provide teachers with basic information on physical disabilities. A history of the physically handicapped is followed by two chapters on anatomical explanations of neuroanatomy and the musculoskeletal system. The third section details the following physical disabilities: cerebral palsy, special health problems (such as allergies, diabetes, and epilepsy), traumatic health conditions, orthopedic handicaps, and chronic or degenerative diseases. Part four reviews sensory disabilities, including visual impairment and multiple handicaps, and speech and hearing impairments. The final section considers specific educational problems facing the physically handicapped student. An overview of psychological testing is provided along with a review of architectural barriers and vocational placement.

Monroe county multicategorical model preschool. Monmouth, Oreg.: Westar, 1981.

The project serves 16 severely to moderately handicapped children, aged three to six years. Four non-handicapped children participate as peer models. The project provides a model for serving young children in the public school system. Comprehensive services to children include integration opportunities, parent education, speech/language, physical and occupational therapy, adapted physical education, health and social services, transportation, and interdisciplinary staffing. The project views parents as planners and advocates for their children. The parent education component is individualized and determined by the parent needs assessment. Parents participate in large and small group meetings, in home visits by the demonstration teachers, and in the development of IEPs. The project's integration/mainstreaming component is a unique feature. There are several levels of integration within the preschool: four normal peer models are integrated into the project classroom; three students are mainstreamed into regular preschool programs; and others are mainstreamed into the least restrictive environment of an elementary school.

National Institute of Education national survey: Follow-up study of non-instructional auxiliary services, ESEA Title I. Washington, D.C.: National Institute of Education (DHEW), 1977.

Eighteen case studies which supplement the national survey of compensatory education are presented. This survey evaluated Title I-funded special services to low achieving students in poor schools, and was conducted by the National Institute of Education. The case studies describe health, guidance, psychological, social work, and other non-instructional services offered in 18 selected school districts. The percentage of Title I funding, selection criteria, district rationales, and the variance in the level of services from 1973-74 through 1976-77 are discussed.

Nutt, A.T. et al. Annual report of the Texas child migrant program, ESEA Title I, 1974-75. Washington, D.C.: Division of Compensatory Education, Bureau of Elementary and Secondary Education (DHEW/OE), 1975.

During 1974-75, 181 school districts in Texas operated programs aimed at eliminating some of the educational deprivation of 61,799 migrant children. The majority of these districts concentrated their greatest efforts in the basic subjects including reading, mathematics, and oral language. Programs were operated in grades K-12 and a special migrant prekindergarten for 4-year-olds. Two types of programs were operated: the 7-month program and the enrichment program. The 7-month program was designed to compensate for the inability of certain migrant children to attend school the entire 10-month term. Enrichment programs were operated on such plans as: extra daily services providing supplementary teachers, or teacher aides providing additional services; an extended day program; or self-contained classrooms with only migrant pupils in a nongraded structure. In all the programs, the objectives were to provide pupils with social services, clothing, transportation, fees, guidance and counseling, psychological services, dental and medical services, and food as well as instructional activities which focused on reading, oral language development, enrichment experiences, English/language arts, and mathematics. This annual report describes the instructional programs and pupil services provided during 1974-75.

Planning instruction for the severely handicapped. Raleigh, NC: Division for Exceptional Children, North Carolina State Department of Public Instruction, 1978.

The manual discusses legal and procedural guidelines established by North Carolina regarding educational services for severely handicapped students. Covered in separate sections are the following topics (sample subtopics in parentheses): definition; placement procedures (referral, screening, school-based committee, assessment, placement, and exit criteria); the instructional program (preplanning, individual education plan, transportation, program accessibility, curriculum areas, classroom design, materials, and instructional techniques); and the educational team (teacher competencies, medical services, occupational and physical therapy services, management suggestions for severely handicapped students with cerebral palsy, psychological services, and speech/language services). Among 14 appendices are bathroom specifications; wheelchair dimensions, a safety checklist; suggested emergency procedures; and a bibliography listing 55 references on language and communication, self-help, education, parents, physical and occupational therapy, and vocational skill training.

Potter, W.H., & Tolley, W.R. Development and implementation of an interagency program for emotionally handicapped children. Fort Lauderdale, Fla.: Nova University, 1977.

The report, over half of which consists of appendices, describes the development and implementation of a program in Dorchester County, Maryland, to integrate into a public school 23 emotionally handicapped students (ages 6-13) who had been attending school at a state mental institution. Services provided to the children in the public school program included individualized and small group instruction, behavior modification and contingency management, psychiatric and psychological services, nursing and health services, recreation, occupational and speech therapy, and parental involvement through outreach services. Among the conclusions reached at the end of the program's first year was that the students exhibited a positive attitude towards the program as indicated by improved attendance, the absence of truancy, and the greater degree of involvement in public school activities. The many appendices include a parental approval form, an inservice schedule, and a list of personnel qualifications.

Preschool conductive hearing impairment language development (preschool child). Monmouth, Oreg.: Westar, 1981.

The project serves approximately 50 children aged birth to 5 years with linguistic handicaps secondary to recurrent otitis media. Children enrolled must have normal development in all areas but language, confirmed language delay, audiological and medical documentation of recurrent otitis media and no evidence of sensorineural hearing loss. The project provides a coordinated triad of services including medical treatment of the otitis condition with ongoing audiological monitoring, supportive parent education and individualized child language development programs for implementation in the home or preschool The curriculum focus is on meeting the auditory processing needs of the target population. Parent education focuses on information needs regarding medical aspects of otitis, audiological testing and meeting the individual language development needs of their child. The project offers support services geared toward effective use of community medical, social and welfare resources. The project promotes awareness within the medical community of the cause-effect relationship between recurrent otitis media and linguistic educational handicaps and uses a coordinated community approach involving the public schools, Head Start, and the Medical College of Ohio.

Redlinger, L., & Eller, R.L. Proceedings of a workshop sponsored by the Texas migrant council on child abuse and neglect in the Mexican American community. Washington, D.C.: National Center on Child Abuse and Neglect (DHEW/OHD), 1978.

The unique needs of migrant farmworkers concerning prevention of child abuse and neglect both at home and at work are presented as the focus of a group of nine workshops. Complex problems facing migrants and their families are discussed in depth in sessions covering services for preschool and school-aged children, special children, emergency services, health services, mental health services, housing, employment opportunities, and legal services. Workshop findings are summarized and four recommendations are analyzed: (1) increased coordination of programs; (2) increased service provisions; (3) increased continuity of service; and (4) a strong migrant advocacy. Appended are specific goals and recommendations by participants--individuals with expertise in migrant housing, employment, social services, health, etc. Among these goals are to improve continuity of preschool services to identify suspected neglect and abuse cases among migrant children as they move from area to area; to provide better outreach and utilization of educational services; to develop a uniform statutory definition of migrant farmworkers; and to encourage health providers to operate within the existing family structure of the farmworker by taking advantage of existing resources in delivery of health care.

Rural service delivery model for school-age handicapped children. Seattle, Wash.: University of Washington, 1981.

The purpose of this project is to establish a service delivery model for rural school districts to provide the best service to school-age handicapped children in rural and remote areas. This model is located within the Northwest Arctic School District in Alaska. The philosophy of the rural service delivery model is that handicapped individuals should remain in their home environment. The project supports the long-range goal of allowing native populations the freedom to structure their own educational programs. The project provides intense training of education personnel, parents, administrators, and community members in the villages to prepare them for students with varying degrees of handicapping conditions. It provides consultants, as necessary, to assure that each handicapped student's needs are met. Other goals include coordinating additional professional resources such as health care, social services, and legal services.

School-Age Parenting Task Force and the Interagency Committee for Services to High Risk Children and Their Families. A comprehensive and integrated model of services for pregnant adolescents, school-age parents and their families in the State of Michigan. Lansing, Mich.: Michigan Department of Public Health, 1979.

Activities which comprise a comprehensive program of services to school-age parents, their children, and their extended families are presented in this model. Outlined are the overall program goals and strategies for implementation. The components of program administration and responsibilities are delineated, and the distribution of allocated funds is described. A flow chart illustrates the funding disbursement and the delivery of services.

The four service components of the program for adolescent mothers are education, health, mental health, and social services. Specific objectives for each and alternative delivery systems are described. Services to the children of school-age parents are also provided through a child care center attached to an alternative school or conventional school program serving adolescents. The document describes the cycle of abnormal child rearing that is prevalent among school-age parents. The personnel, objectives, and services provided are outlined for the four program components. A program for fathers is also described which includes outreach, counseling, and informal group discussions. Services to the extended families include educational and counseling services delivered through group meetings, parent interviews, and home visits. Other facets of the comprehensive program are providing outreach services to students who have dropped out of school, and teaching responsible sexuality. The implementation of each of these is described.

Selected topics of interest: 1981. (Part I) American Annals of the Deaf, April 1981, 126(2), 93-121.

The special topics section of the journal contains four papers with information on psychological, health, and educational service providers for hearing impaired children. Included are the following titles and authors: "Profile of Psychological Service Providers for Hearing Impaired Students" by A. Spragins, *et al.* (reports a study on the characteristics of 808 professionals); "Health Care Delivery for Deaf Patients--the Provider's Role" by L. DiPietro, *et al.* (looks at some of the barriers which impede health care services and offers suggestions to reduce these barriers); "Otologic Survey of Schools for the Deaf" by S. Rood and S. Stool (details awareness and diagnostic elements of middle ear disease in the school-age deaf child); and "Hearing Impaired Children from Non-native Language Homes" by G. Delgado (contains results from a survey of 3,011 children).

Sullivan, O.R. Meeting the needs of low income families with handicapped children. Journal of the International Association of Pupil Personnel Workers, Winter 1981, 25(1), 26-31.

The author discusses the role of pupil personnel workers and educators in providing services for handicapped children of low-income families. Parents need to be aware of their children's rights and the services available in the community and the school. Parent involvement should be encouraged.

Walley, B. Parents can make a difference. Journal of the International Association of Pupil Personnel Workers, Winter 1981, 25(1), 22-25.

Parents, like teachers, must make every effort to create environments that are physically, socially, and emotionally conducive to self-exploration and communication. Schools should be more responsive to parents and more willing to provide nonacademic services and information to the family.

Health Services

GENERAL

Conyers, C.L. Summer programs offer "three squares". School Foodservice Journal, July/August 1972, 26(7), 88-90.

The article discusses a program for children of migrant workers and others who are disadvantaged, providing three meals a day, medical attention, school, and motivation for more education. This program is being carried out in Accomack and Northampton Counties in Virginia.

Wallace, H.M. Health care of children in the U.S.S.R.--1979. American Journal of the Disabled Child, January 1981, 135(1), 15-17.

Wilner, D.M., Walkley, R.P., & O'Neill, E.J. Introduction to public health (7th ed.). New York: Macmillan, 1978.

Written for beginning and intermediate students in training programs for the health professions, the textbook discusses major health programs in the United States (objectives, sponsorship, costs, outcomes, and accomplishments) and personnel opportunities, requirements, and qualifications. Topics considered are the framework of public health (1970s and 1980s, organization of services, health workforce and professions); medical care, mental health, environmental health; health and disease of population groups; and selected public health supportive services (research; health education in the community; laboratory, pharmacy, and nutrition services).

Brown, O.C. OEO--The emergency food and medical services program and nutrition education. Proceedings of the Nutrition Education Seminar of Florida Agricultural and Mechanical University, July 18-28, 1971, pp. 70-71.

This paper discusses the development of the emergency food program in 1968, the new school lunch law in 1971, and resources available through federal food programs such as special information booklets, commodity foods, and food stamps. Implications of these programs for nutrition education are presented.

Fulton, G.P. Nutritional betterment through higher education: Remarks by statewide leaders at a planning session for a statewide conference on nutrition education, April 21, 1976. Orangeburg, S.C.: South Carolina State College, 1976.

Eighteen participants in a planning session sponsored by the South Carolina Commission on Higher Education presented their ideas for nutritional status in South Carolina. Proposals to meet the goal of nutritional betterment included: introducing state licensing for nutrition professionals; statewide planning for nutrition education and delivery of nutritional services; clinical training for nutritional care; teacher preparation, integrated curricula, and a variety of educational programs in nutrition; and the sharing of nutrition specialists by educational institutions.

Kaufman, M., Lewis, E., Hardy, A.V., & Proulx, J. Families of the fields. Jacksonville, Fla.: Florida Department of Health and Rehabilitative Services, 1973. (Monograph)

This monograph is a result of a study done in two South Florida communities on the nutritional status of the families of seasonal agricultural workers, and is designed to be of interest and value to agencies and individuals concerned with the well-being of these people. The report includes an outline of the project, the survey procedure used and its findings, a description of a follow-up intervention program developed to meet the needs uncovered in this survey, and the evaluation of this intervention program. Various tables and graphs are included to further clarify the findings presented. Modest demonstrable dietary changes in the group as a whole along with substantial modifications in the eating habits of individual families were found to result from this program. Specific recommendations are made for the routine incorporation of nutrition surveillance in ongoing health services for these workers as well as for increased efforts in nutrition education that are comprehensive and long-term. References and sample forms used in the survey as well as standards for obesity status and group blood and urine data are given.

Lachance, P.A. Nutrition and the public health. Food Product Development, June 1973, 7(5), 52; 54.

The most significant result of balanced nutrition is long-range health--soundness and vigor of body and mind. Sociopsychological factors make food habits hard to change. Thus food guides (the basic four, Type A lunches, etc.) have not increased the quality of the American diet, nor prevented a serious nutritional deterioration. Add to this the increased consumption of convenience foods, and deterioration of overall U.S. nutritional status should be expected. We spend 97% of the federal budget for health on medical services, and 3% on nutrition and prevention of health problems. People must become educated to the fact that good nutrition, along with good hygiene is the best weapon available in the prevention of disease. Once people learn to recognize, prepare, and eat nutritious meals, then the medical bills will go down and the general level of health will increase proportionally.

League of Women Voters Food for All, Inc. Food for all: A handbook. Washington, D.C.: Author, 1972.

This booklet gives detailed summaries of current government food programs. The responsibilities of local, state, and federal authorities and the rights of participants are outlined. Topics covered include food stamp and distribution programs, school lunch and breakfast programs, and programs of supplementary feeding. Of interest to the consumers concerned, as well as to directors of school lunch and other feeding programs.

Rowland, A.M. Nutrition education through a health program. Proceedings of the National Nutrition Education Conference, Washington, D.C., November 2-4, 1971, April 1973, pp. 59-62.

Ann Rowland discusses how the Children and Youth Project, University of Alabama Medical Center, works to deliver nutritional services to the adolescent and the family of the teenager in Jefferson County, Alabama. The different approaches that the nutritionist can take and the activities that have proven most effective are discussed. Nutritionally adequate food habits have to be formed by the adolescent, and this is the job of the nutritionist in this program.

Walker, A.R. Some thoughts on malnutrition, dietary intervention and amelioration of high death rates in young South African blacks. South Africa Medical Journal, April 26, 1980, 57(17), 696-700.

In South Africa, mortality rates from nutritional deficiency and infectious diseases among the very young are lower in whites than in the other ethnic groups, particularly blacks. Among black preschool children, 25-35% are under the 3rd percentile of weight for age according to Harvard reference standards, and orthodoxly, exhibit protein energy malnutrition. The proportion is even higher among black scholars until late puberty. Many, particularly overseas, believe that direct or indirect dietary intervention by health authorities could ameliorate these situations to a tremendous extent. In fact only dietary intervention in the very young is likely to significantly improve morbidity and mortality rates. Elsewhere, intervention during school years has usually failed to yield unequivocally beneficial results, and the same applies as regards supplements in pregnancy and lactation and their effects on morbidity and mortality in infants. All these uncertainties underline the need, emphasized by World Health Organization bodies, to carry out definitive controlled elucidatory studies. As regards non-dietary measures relating to medical services, water supply, socio-economic level and health education (particularly nutritional), while all these are mandatory, elsewhere their beneficial effects have often been slow in forthcoming or have been of uncertain clinical value. There is no universal "blueprint" for reducing morbidity and mortality rates from malnutrition in developing populations. Preventable adverse health situations in the young in other parts of the world are by no means limited to third world populations.

DENTAL

Blaikie, D.C., & Weidenhofer, R.N. The cost of school dental care: A preliminary economic analysis. *Australian Dental Journal*, April 1978, *23*(2), 146-51.

The cost of school dental care provided by the South Australian School Dental Service is compared with the cost of funding similar care through an hypothetical alternative based on fee-for-service. The results of both cost-benefit and cost-effective analysis suggest that the school dental program is an economically acceptable method of delivering school dental care.

Ceravolo, J. School dental service surveys. *Australian Dental Journal*, 1981, *26*(4), 260.

Christensen, J. Better oral health for children--the Danish model. *International Dental Journal*, September 1980, 30(3), 269-75.

Since 1972 a public, fully subsidized municipal school dental service has been established in Denmark. The school dental service comprises general and individual preventive measures, regular dental examinations and all odontological treatment needed to keep the masticatory system in a good functional order. At the same time a recording system for the oral health of children was established. Information from the school dental service and private practitioners on the oral condition of children is passed to the dental division of the National Health Board. The statistics, published once a year, have proved extremely valuable for evaluation and planning purposes. The school dental service on a nationwide scale has been functioning for too short a time to allow a final conclusion to be drawn. However, a positive trend in the caries experience of children may already be seen as a possible result. The importance of a regular dental service for children and of regular visits to a dentist for adults is illustrated. The problems arising when children leave school and pass from the school dental service to the national health insurance system are discussed.

Douglass, C.W., & Cole, K.O. The supply of dental manpower in the United States. Journal of Dental Education, May 1979, 43(5), 287-302.

This description of the supply of dental services in the United States addresses the number, kind, distribution, and training of dentists and dental auxiliaries, and the organizational factors that affect the production of dental services. Beginning with a brief historical review, the paper gives a general overview of the different types of dental personnel including the dentist, dental hygienist, dental assistant, and laboratory technician. The discussion of these categories of providers includes consideration of manpower planning as it has evolved over the past two decades. National manpower legislation is mentioned first as a reaction to the projected dentist shortage and then in response to the issues of geographic maldistribution and the effects of specialization. The second section of the paper discusses the dynamics of the dental care market. The distribution of the supply of services is identified and related to patterns of utilization and productivity. These factors are considered to be part of the set of dynamic relationships that help explain the current manpower problems of geographic and specialty maldistribution. A concluding section superficially discusses policy implications regarding the potential for increasing supply by: (1) increasing the number of dentists, (2) increasing the numbers and functions of auxiliaries, (3) increasing practice efficiency through group practice, and (4) reducing the restrictions that result from current state dental practice acts.

Doyle, A.J., Renner, W.A., & Mellor, J. Co-ordination of the school and general dental services in Rochdale, England. Community Dentistry and Oral Epidemiology, February 1979, 7(1), 6-10.

The administrative process in the implementation of a scheme of cooperation between the school and general dental practitioner services to screen and treat children aged 14 years and above in an area health authority is described. Eighty-four percent of the target group were screened in periods amounting to 12 months. The uptake of treatment as assessed by return of notices of referral was only 1.5%. Interview of a sample of those referred revealed that 49% had been to a dentist within six months and of these 34% would not have otherwise attended. Thirteen percent had taken referral forms to practitioners. The implications of these findings are discussed and a more effective means of evaluating treatment uptake is proposed.

Dunning, J.M., & Dunning, N. International look at school-based children's dental services. American Journal of Public Health, 1978, 68(7), 664-668.

Hancocks, S.A. The community dental service. A personal viewpoint. Apex, Spring 1979, 11(1), 30-33.

Lennon, M.A., & Taylor, G.O. Dental services for children in England and Wales. British Dental Journal, February 19, 1980, 148(4), 107-9.

Melville, M.R., Pool, D.M., Jaffe, E.C., Gelbier, S., & Tulley, W.J. A dental service for handicapped children. British Dental Journal, October 20, 1981, 151(8), 259-61.

Rise, J., & Haugejorden, O. Monitoring and evaluation of results of community fluoride programs in Norway during the 1960's and 1970's. Community Dentistry and Oral Epidemiology, April 1980, 8(2), 79-83.

The purpose of this paper was to report on the introduction, functioning and results of community fluoride programs in Norway during the 1960's and 1970's. Data on the treatment carried out in the school and public dental services were available in official publications. Information on systematic community topical fluoride programs for priority groups was collected by postal questionnaire from all school and public dental officers.

Sundram, P.S., & Kingston, A.I. Questionnaire survey on parental attitudes of the South Australian school dental service. Australian Dental Journal, 1981, 26(2), 77-79.

Underhill, D.A.S. Oral health status of trainable mentally retarded children and their parents' and teachers' attitudes toward dental health. Ann Arbor, Mich.: University of Michigan, 1979.

There was no significant difference in oral health status for trainable mentally retarded children whose support people attended a dental health education preventive program learning session. However, the number of children who received dental services increased during the time of the study.

MEDICAL

Alternative units for Health II, senior high. Belmont, Calif.: Fearon Reference Systems, Division of Pitman Learning, Inc., 1976.

This guide outlines content, concepts, objectives, and activities in seven areas under health education. Topic includes: environmental health, medical services, nutrition, standard first aid, personal safety, health as related to work, and health careers. Activities focus on research and seatwork.

Bryan, E. et al. Medical considerations for multiple-handicapped children in the public schools. Journal of School Health, February 1978, 48(2), 84-89.

The article discusses medical considerations for multiply handicapped children in the public schools and in public preschool programs. Covered are first aid, emergency care, and disaster planning; sanitation; environment; safety in routine activities; safety in supplemental activities; therapy procedures; staff protection; training and orientation of staff; and special qualifications of staff. Included are practical suggestions regarding the management of the situations cited. (Article also appears in Bureau Memorandum, 1979, 20(3), 5-9.)

Cava, E. et al. A pediatrician's guide to child behavior problems. New York: Masson Publishing USA, Inc., 1979.

The text addresses the role of the pediatrician in primary and secondary prevention of child behavior problems. Among primary prevention topics are the effect of having a child in the home, specific issues from birth to 5, the chronically ill child, problems related to death, and problems in children with divorced or separated parents Secondary prevention topics include speech problems, general school problems, learning disabilities, psychosomatic problems, sexual problems, and communication with parents.

Duke, P.M. The role of the pediatrician in the adolescent's school. Pediatric Clinics of North America, February 1980, 27(1), 163-171.

The article reviews the role of the pediatrician in the adolescent's school with emphasis on methods of involvement. The following two school health models are discussed: (1) the interpretive medical service model, in which pediatricians provide consultation about individual students and the "health" of the school itself; and (2) the direct medical service model, in which health care is delivered in the schools. Three aspects of adolescent health education (potential sources of knowledge about health that are available to adolescents, the pediatricians' interaction with these sources, and the way adolescents learn) are explored in the final section.

Frankenburg, W.K. (Ed.). Child health in the eighties: A conference held at the John F. Kennedy Child Development Center, University of Colorado Sciences Center, Denver, Colorado, February 15, 1980. Washington, D.C.: Department of Education, 1980.

Proceedings from a 1980 symposium on the delivery of education and health services to handicapped children are summarized. Topics briefly addressed include funding, leadership and responsibility, communication and trust, and coordination and collaboration strategies. Fifteen conference recommendations are listed, including that each level of government should establish and/or publicize funding priorities for child health programs; that fiscal rewards should be established to encourage innovative efforts; and that health agencies, schools, and social service agencies should plan together for programs that complement each other. Abstracts of 31 model collaborative projects presenting innovative service delivery schemes are presented along with abstracts of seven model training/curriculum programs. Program summaries are followed by names and addresses of contact persons.

Gortmaker, S.L. Medicaid and the health care of children in poverty and near poverty: Some successes and failures. Medical Care, June 1981, 19(6), 567-82.

Recent trends in access to and utilization of health services by children living in poverty, near poverty, and higher income households in the Flint, Michigan, metropolitan area are examined. During the period under study (1973-1977), there were substantial increases in the percentage of poor children enrolled in Medicaid. By 1977, however, 15 percent of children in poverty in the city of Flint were still not enrolled; in suburban areas, this estimate was 30 percent. Some correlates of non-enrollment are identified. These changes in Medicaid enrollment were accompanied by an attenuation of differences in the utilization of ambulatory medical services among income groups, although children on Medicaid in 1977 were still less likely to have a regular source of care, and less likely to have a pediatrician as a regular physician. Although dental visits were covered by Medicaid beginning in 1975, economic differentials in dental utilization appear to have widened over the period under study. A variety of barriers to the delivery of services under Medicaid in this community are noted, and the generalizability of these findings discussed.

Harley, R.K., & Lawrence, G.A. Visual impairment in the schools. Springfield, Ill.: Charles C. Thomas, 1977.

Intended for teachers, nurses, school health personnel, and parents, the volume provides information on the structure and function of the eye, its diseases, and the relationship of visual impairment to visual learning. Section I on medical aspects of visual impairment presents an overview of the anatomy of the eye, a discussion of optical defects and disturbances of ocular motility, and descriptions of ocular abnormalities affecting areas adjacent to the eye and eye surface as well as common internal diseases of the eye. Part II, covering the education of children with low vision, reviews studies of recognition of children with visual problems, control of environmental factors, optical aids for low vision pupils, educational implications of certain eye conditions common to children, and visual perceptual learning. Appended are notes on the role of the regular classroom teacher, a listing of sources for educational materials, a guide for visual testing, and a glossary of approximately 100 terms.

Hass, G., & Scovell, M. A guide to administration, diagnosis, and treatment for the early and periodic screening, diagnosis, and treatment program (EPSDT) under Medicaid. Bethesda, Md.: Health Services and Mental Health Administration (DHEW), 1977.

Provided are guidelines on administration, diagnosis, and treatment in federally funded EPSDT--early and periodic screening, diagnosis, and treatment programs, a system for providing health care services to children eligible for Medicaid. Detailed in Part One are factors involved in developing EPSDT programs. Four chapters consider the need for EPSDT; available resources (including school health programs, neighborhood health centers and health maintenance organizations); organization of services (such as outreach workers and health aides); and fiscal and program evaluation aspects (including budget development, cost efficiency, and reimbursement). Part Two focuses on diagnosis, treatment, and follow-up services in EPSDT. A chapter discusses diagnosis and management of problems such as vision and hearing impairment, growth and nutrition disorders, and developmental problems.

Hummel, L.B. School functioning of hemophilic males on home-infusion therapy. Ann Arbor, Mich.: University of Michigan, 1978.

Evidence from data on 27 hemophilic males (4 to 18 years old) indicated that school functioning of hemophiliacs was quite normal; and that home infusion therapy using concentrated clotting factors decreased absence rates for these students.

Jenne, F.H., & Greene, W.H. Turner's school health and health education (7th ed.). St. Louis, Mo.: C.V. Mosby Company, 1976.

This textbook for the health educator is a revision of a text written by the late Dr. Clair E. Turner. The following topics are covered in depth: (1) nature and development of school health and health education; (2) organization and administration of school health and health education; (3) school health education; (4) school health services; (5) healthful social, emotional, and physical environments; (6) health promotion and health problems; (7) appraising school health and health education. Two appendices list instructions for the control of the more common communicable diseases in the school and first-aid procedures.

Levangie, P.K. Public school physical therapists: Role definition and educational needs. Physical Therapy, June 1980, 60(6), 774-79.

Questionnaires returned by 328 physical therapists were analyzed to establish a role definition for public school therapists and determine the educational needs of therapists preparing to work with handicapped students. The therapists ranked 15 skills in importance to the role of the public school physical therapist and in urgency of their need to develop each skill. They also indicated which educational format they believed would be most appropriate for developing each skill. The respondents were divided into four groups matched by experience in treating children and by exposure to public school physical therapy. Rank order correlations within each of these four groups showed little similarity in their perception of the public school therapist's role or in their own educational needs. Between group correlations based on averaged role definitions and educational needs were high. Generated role definitions indicated the tendency of therapists to perceive themselves as part of the traditional medical model, rather than as participants in the educational process.

March of Dimes. Preparenthood education program kit. White Plains, N.Y.: National Foundation March of Dimes, 1978.

The materials included in the preparenthood education program kit provide adolescents with information on prenatal health care and nutrition. The kit includes publications which are easy to read and relevant to the needs and interests of teenagers such as comic books, fact books, posters, a developmental time-line chart, information cards, and teachers' guides. The materials stress the importance of pregnant adolescents receiving medical care as early as possible. Medical checkups are described as well as the growth of the fetus inside the womb. Suggestions for caring for newborn babies are also provided. The fact books provide nutritional information, describing the four basic food groups and giving suggestions for healthy snacks. A list of healthful ethnic foods is also presented. One comic book, "The Junk Food Blues," presents teenaged characters that discuss the importance of eating healthful foods. "Days of Change" presents the story of a young woman who becomes a mother, and it describes the health precautions she follows. The materials were designed for use in junior and senior high schools, special education programs, prenatal care clinics, hospitals, neighborhood health centers, and centers for single parents.

Medical emergencies and administration of medication in school. Pediatrics, January 1978, 61(1), 115-116.

The American Academy of Pediatrics' Committee on School Health recommends specific steps for medical emergencies in school and lists seven regulations governing the administration of medication in school.

Medical emergencies and administration of medication in school. Journal of School Health, May 1978, 48(5), 275-276.

The article discusses how a school should handle medical emergencies and the administration of medication. Among the suggestions presented are the availability of an emergency medical kit in each school, and the presence of a locked cabinet for storing medicine.

Resnick, M., Blum, R.W., & Hedin, D. The appropriateness of health services for adolescents: Youth's opinions and attitudes. Journal of Adolescent Health Care, December 1981, 1(2), 137-41.

Minnesota high school students were surveyed about their attitudes, beliefs, and opinions about health, illness, and medical care. Data were obtained from small group discussions conducted by the adolescents themselves in schools and agencies throughout the state. This paper reports their views toward adolescent medical services. Teenagers emphasized the idea of service appropriateness as central to promoting service utilization. Key to the concept of appropriateness were the components of staff, cost and confidentiality. Each of these dimensions is examined from the view of youth as to implications for increased appropriateness of services for both utilization and improved health. Findings are discussed in terms of differences in problem definition between the adolescent and professional, and their implications for medical care in conventional and alternative settings.

Schubert, D.G. The status of visual screening in today's schools. Paper presented at the Annual Meeting of the International Reading Association, Anaheim, California, May 1976.

Vision is so important to scholastic success that almost all states require by law some kind of vision testing of school children. The ideal visual screening program would involve the kind of test or tests a classroom teacher could administer and would be fast, thorough, and accurate. However, present commercial vision screening batteries fail to measure up to these criteria. The Snellen Test is inadequate because of its very high underreferral rate, while the most popular screening test instruments, the Telebinocular and Ortho-rater, have been criticized for over referring children to vision specialists. Unfortunately, the most superior vision screening method that can be used in schools--the Modified Clinical Technique--proves unfeasible because of the difficulty and cost of bringing a team of specialists to the school. What is needed is a simple screening test that would have the validity of the Modified Clinical Technique test at a fraction of its cost.

Schwenn, J.O. What are the definitive procedures and instruments used to incorporate chemotherapy orientation and preparation for effective team membership, during inservice and preservice training of teachers and administrators. Paper presented at the 58th Annual International Convention of the Council for Exceptional Children, Philadelphia, April 1980.

An administrator discusses aspects of drug therapy with which special educators should be familiar. Briefly examined are administration form, factors affecting rate of absorption, dosage, interaction of one drug with another, drug tolerance, time factors, and side effects. The importance of a teacher's monitoring of the drugs is stressed, and examples of the types of teacher observation are described.

Solan, H.A. Learning disabilities: The role of the developmental optometrist. Journal of the American Optometric Association, November 1979, 50(11), 1259-66.

The role of the optometrist in treating children experiencing learning disabilities (LD) is discussed. Etiological, diagnostic, and therapeutic factors are explored stressing visual functional disorders, perceptual/motor and developmental lags, and cognitive style. Their effects on the LD child are analyzed; and the rationale of optometric procedures frequently used in treating LD children is reviewed.

Sommers, P.A. Standardizing medical-educational services for exceptional children: A focus on mental retardation. Paper presented at the First World Congress on Future Special Education, Stirling, Scotland, June 25--June 30, 1978.

The paper describes a medical-educational model which systematically integrates services and follow-up activity in a standard manner for exceptional children, particularly the mentally retarded. The report reviews model elements and shares experiences with an emphasis on stimulating other health care service groups to consider standardizing medical-educational services.

Sommers, P.A., & Fuchs, C. Pediatric care for exceptional children: An inferential procedure utilizing consumer satisfaction information. Medical Care, June 1980, 18(6), 657-67.

Medical services provided to 402 children with exceptional health and educational needs between 1975 and 1978 were systematically studied to determine consumer satisfaction. Legislation (PL 94-142) has made it mandatory for complete services to be provided to exceptional children from birth to age 21. Although the major responsibility to provide these services lies with local public schools, physicians often are involved and can help to provide optimum care to these children. This report describes a medical-educational system that delivers multispecialty pediatric services. An inferential evaluation procedure has been applied to this system that shows how consumer input can lead to improved medical services. Statistical procedures used to examine the data include analysis of variance, utilized in comparing the satisfaction ratings over time, and multiple linear regression analysis, to predict medical service activities of importance to consumers.

Steenson, C.B., & Sullivan, A.R. Support services in the school setting: The nursing model. Journal of School Health, May 1980, 50(5), 246-49.

A health service delivery model is presented for the care of handicapped children. The components of this model are identification of primary instructional goals in special education programs, determination of need by medical and diagnostic services, and development of school health services to support such programs.

Taylor, C. et al. Behavioral medicine approach to the care of the patient with spina bifida: Intervention for independence. Spina Bifida Therapy, October 1979, 2(2), 165-94.

The behavioral medicine approach to spina bifida involves a multidisciplinary focus on prevention; treatment (biofeedback or behavioral procedures); and health care delivery (use of behavioral techniques to maintain patient compliance to prescribed medical regimens). A 3-year study is underway to examine the behavioral medicine approach to the prevention and treatment of psychosocial and medical problems secondary to spina bifida in 50 adolescents and young adults and 50 children. Self care skills, health care delivery, social skills, and vocational development will be examined.

A three-year plan designed to provide inservice training. Bloomington, Ind.: National Inservice Network, Indiana University, 1981.

This project describes a three-year plan for the development and presentation of inservice training institutes which are intended to reach a wide range of personnel throughout Wisconsin. Each institute, its title and suggested content is described below: 1. Vocational career method and models on secondary level programming for students having exceptional educational needs; 2. Interdisciplinary approach--inservice update: medical aspects of special education early age handicapped children (to serve primarily 25 special teachers, 25 parents, and 15 regular teachers); 3. Inservice for regular education teachers: mainstreaming for hearing and visually impaired students (to serve approximately 100 regular teachers, 40 principals, 20 parents). Major objectives are to: provide opportunities for interface and cooperative interaction between regular teachers and administrators along with special educators of severely handicapped, emotionally disturbed, learning disabled and profoundly mentally retarded children, in developing common understanding and strategies for providing career-vocational training to secondary handicapped children; provide and develop a network of communication, cooperation, through a broad-based inservice program plan, as embodied in the SEA state plan for a comprehensive system of personnel development including SEA, IHE, LEAs, and other state agencies concerned with vocational and career education of secondary level handicapped youngsters; combine the thrusts toward 1) provision of inservice training for regular and special educators; and 2) provision of related, supportive services to handicapped children by promoting activities, workshops, which demand co-involvement and co-direction by representatives of the medical-support services sector and the educational sector.

Walton, H.N. *et al*. *Comparison of vision screening by the modified telebinocular technique and the modified clinical technique*. Paper presented at the 21st Annual Meeting of the International Reading Association, Anaheim, California, May 1976.

This paper reports an investigation of the effectiveness of vision screening by the Modified Telebinocular Technique (MTT) when compared to the more cumbersome but highly valid and reliable Modified Clinical Technique (MCT). Data on 102 school children were collected using the MCT. The same children were then given the MTT to establish comparison data for the various visual anomalies that can be detected by the MCT. A statistical analysis of the data demonstrated a significance of greater than the .01 percent level of confidence, indicating that the MTT vision screening procedure will provide results which are comparable to the MCT.

Wold, S.J., & Dagg, N.V. School nursing--a framework for practice. *Bureau Memorandum*, 1979, *20*(3), 2-5.

A conceptual framework for school nurses in structuring their practice is provided. The following five concepts are considered as part of the framework: public health, adaptation, helping relationships, systematic process, and tools. Each concept is defined, a rationale for its inclusion is given, and examples illustrating its applicability to school nursing are included.

Psychological Services

Ahrens, D.C. *Psychological services in Pittsburgh's north side schools: 1966-1967* (Doctoral dissertation, University of Pittsburgh, 1971).

Bernstein, M.E. Psychotherapy in the schools: Promise and perplexity. *Journal of School Psychology*, Winter 1976, *14*(4), 314-320.

The child resource team was designed to operate as an alternative to outside agency referral. The multidisciplinary unit provides intensive therapy to school-aged children and their families. Following two years of operation, an analysis of the team's successes and failures has revealed significant gains and difficulties.

Brannen, B.L. *Beginnings of psychological service in three school systems* (Doctoral dissertation, Harvard University, 1960).

Cantor, D.W., & Spragins, A. Delivery of psychological services to the hearing-impaired child in the elementary school. *American Annals of the Deaf*, June 1977, *122*(3), 330-336.

Described are tools and techniques by which practicing school psychologists can expand their skills, knowledge, and competencies in the areas of assessment of intelligence, visual-motor integration, and emotional development; educational planning; counseling and consultation to become effective in dealing with hearing-impaired elementary level children. The limitations of a psychologist untrained in manual communication are discussed.

Cassel, A.M. *The Oxford School--A study of the organization and administration of a private high school with special emphasis on its program of guidance and psychological services* (Doctoral dissertation, Yeshiva University, 1959.

Cook, J.A. *Referrals to psychological services of Knox County schools: Description and outcomes* (Doctoral dissertation, University of Tennessee, 1979).

Counselling and guidance in Norway--A brief summary. Paper presented at the 8th International Round Table for the Advancement of Counselling, Oslo, Norway, July 2-6, 1978.

This brief overview of counseling and guidance in Norway presents the services available to children and young people, including the school-psychological services, counseling in the schools and colleges, and the labor offices, which offer occupational guidance services. Educational requirements and functions are indicated for each of these services.

Davis, M.E. *The status of psychological services in the public schools of Tennessee, 1975-1976* (Doctoral dissertation, University of Tennessee, 1976.)

Elementary school basic guidance system: Grades K-4. ESEA Title I, 1976-77. Washington, D.C.: Office of Education (DHEW), 1976.

This report describes the ESEA, Title I Elementary School Guidance Program instituted in 22 Norfolk elementary schools. The primary purpose of the program is to provide an organized developmental service that promotes positive child growth and development. This is to be accomplished through zealous efforts to achieve the following objectives: (1) to aid children in their school adjustment and academic development; (2) to assist children in their personal growth; (3) to assist children in their social development; (4) to help children develop adequate human relation skills; (5) to help children understand the world of work; (6) to assist children to alleviate personal, behavioral, and emotional problems; and (7) to aid children in the development of problem-solving skills. Some of the activities included in the program are: identifying pupils with special needs, assisting with placement of pupils, counseling individually and in groups with children who have learning, behavioral, and emotional problems, conducting small group guidance sessions with pupils, and conducting parent study group sessions. It is felt that these continuous activities and approaches will lead to fewer delinquents and dropouts.

Evans, P.L. *South Carolina Department of Education initiatives in school psychology: Briefing paper*. Columbia, S.C.: South Carolina State Department of Education, 1980.

The paper reviews initiatives the South Carolina Department of Education has undertaken in the area of school psychology, particularly as it pertains to evaluating and placing handicapped children. Two brief introductory sections cover the role, function, and certification of school psychologists and national approaches toward the delineation of standards for practice (including specific responsibilities of psychological services required under P.L. 94-142 (the Education for All Handicapped Children Act). School psychology in South Carolina is reviewed in terms of present state requirements, approved training programs, and nondegree certification. Results of a South Carolina survey of teachers and administrators as well as a survey of school psychologists are summarized with such findings as a perceived need by teachers and administrators for more student counseling and a perceived need by psychologists to review current certification standards. Initial activities of a South Carolina task force which is examining standards for the role, function, and certification of school psychologists are described.

Feiner, J.S., & Tarnow, J.D. Expanding the base for child mental health service and training. Journal of Special Education, Spring 1977, 11(1), 49-58.

Described is a program in which mental health services coordinated by a physician intern were provided in a New York City school. Three program aspects are discussed: school consultation for referral of problem students to appropriate community services; problem solving groups for parents, teachers, and children; and meetings for teachers in which the development of support systems was encouraged. Advantages of the model are seen to include encouragement for participation of parent and community resources in the school setting.

A final program report from Indiana University-Indianapolis Public Schools inner city counselor training project, 1971-1974. Washington, D.C.: Office of Education (DHEW), 1974.

Recognizing the need for improved, more flexible, more reality-based training for pupil personnel workers, the Division of Foundations and Human Behavior, Indiana University, in conjunction with the Department of Counseling and Guidance, formed a relationship with the Indianapolis Public Schools in order to seek out methods of improving PPS training. A major goal of this satellite project was to bring together university staff, parents, and teachers for the purpose of collaborative planning and programming. The satellite operations formally extended over three project years. During the first year the goals of the target communities, schools, and university were defined and synthesized. Needs of the schools and communities began to be assessed (and continued to be throughout the project). From the needs assessment came the development of training modules for university students, community persons, and school staff members. These efforts dominated the activities of the second year. In the final project year the training programs continued, but greater emphasis was placed upon institutionalizing desirable changes at school, university, and state educational levels. Dissemination of project findings and evaluations then began. Key features of the satellite project were: (1) collaboration and planned systems change, (2) learning by doing, (3) competency-based learning, and (4) incorporating an inner city counseling program with an attending course of study. The program had considerable impact.

Foster, S.L., & O'Leary, K.D. Teacher attitudes toward educational and psychological services for conduct problem children. Journal of Abnormal Child Psychology, 1977, 5(2), 101-111.

Ninety-nine elementary school teachers participated in a survey designed to assess teacher attitudes toward and experience with a variety of strategies for dealing with conduct problem children in regular classes. Results indicated that a majority of teachers favored placing conduct problem children in regular rather than special classes; that current sources of assistance (school psychologists, clinical psychologists, principals, parents, and other teachers) were uniformly perceived as only slightly effective in helping teachers handle problem children; and that of 14 alternative educational and psychological assistance delivery strategies, teachers most frequently preferred smaller classes, teacher aides, increased counseling staff, and resource classrooms.

Friedman, F.T. The origins and development of psychological services in the public schools of Buffalo, New York (1906-1980) (Doctoral dissertation, State University of New York at Buffalo, 1981).

Gargiulo, R.M. et al. Perceived role and function of Ohio school psychologists. Perceptual and Motor Skills, April 1981, 52(2), 363-72.

A randomly selected group of teachers, principals, and school psychologists were surveyed. Demographic variables, relationships with school psychologists, and preference ratings in five areas--referral priority, information-gathering techniques, utilization of the school psychologist, effectiveness with exceptional children, and remediation strategies--were examined. Contradictory perceptions among respondents are discussed.

Gerken, K.C., & Landau, S. Perceived effectiveness of school psychological services comparative study. Journal of School Psychology, 1979, 17(4), 347-354.

Goldwasser, E.G. Effect of recent legislation for handicapped children on school psychological service in New York State (Doctoral dissertation, Fordham University, 1979).

Greer, R.M. A cooperative effort: That's the key. School Counselor, May 1976, 23(5), 362-364.

Counselors are the mental health specialists in the schools, according to the author. As such, they should call upon the community's mental health services in an effort to provide better school services through a cooperative effort.

Grimes, J. (Ed.). Psychological intervention: Case studies in school psychological services (Vol. 1). Des Moines: Division of Pupil Personnel Services, Iowa State Department of Public Instruction, 1977.

The case studies presented by seven school psychologists illustrate the nature and scope of psychological intervention with emotionally disturbed and otherwise handicapped students. Included are papers with the following titles and authors: "Desensitization--An Approach to the Elimination of Phobic Behavior" (E. Asmus); "Reduction of Classroom Noise with a DRL (Differential Reinforcement of Lower Rates) Reinforcement Schedule" (P. Bowser); "Reducing Self Stimulatory Behavior by Increasing Talk Behavior in an Elementary School Boy" (J. Heider); "The Use of Behavior Modification in Attempting to Elicit Verbalization from an Effectively Mute Child" (R. Ranes); "The Use of Tapes and Textbooks Together for Non-Readers in High School" (E. Schrader); "Contact System to Improve and Increase Assignments Completed and Decrease Fighting Behavior" (B. Thomson); and "A Method of Increasing and Redistributing Praise Rates and Suppressing Negative Interactions of Preschool Teachers" (W. Wright).

Grimes, J. (Ed.). Psychological intervention: Case studies in school psychological services (Vol. 2). Des Moines: Division of Pupil Personnel Services, Iowa State Department of Public Instruction 1978.

The 16 case studies illustrate the nature and scope of psychological intervention with emotionally disturbed and otherwise handicapped students. Included are papers with the following titles and authors: "Reducing Math Anxiety While Increasing Independent Work Habits in a Learning Disabled Elementary School Boy" (K. Hoogeveen); "Coping with Special Student Needs in the Absence of Appropriate Programs--A Case Study" (R. Smiley); "Wide Band Behavioral Treatment of a Socially Isolated Child" (M. Shepp); "Modifying Covert and Overt Manifestations of Anxiety Through a Multi-modal Approach" (R. Ranes); "Decreasing Aversive Off Task Behavior of an Early Elementary Student" (B. Rasch); "Electronic Head Positioning Device for Multiply Handicapped Adolescent" (P. Bowser); "Developing Socially Acceptable Behavior Using the Student's Values and a Data Based System" (D. Dierks); "The Responsive Teaching Model--Focus on the Mentally Retarded (J. Meyers); "Counseling with the Suicidal Student" (O. Dodson); "Using

Self Management to Reduce Complaining Behavior" (M. Hansen); "Successful Treatment of School Phobia in a 15-year-old Male" (R. Kerr); "Diagnosis and Servicing of a Learning Disabled Child Compounded by Delayed Neurological Impulse Control" (W. Gould); "Reduction of Distractibility in a Fourth Grade Female Through the Reduction of Caffeine and Nicotine Intake by the Mother" (R. Kerr); "Increase in School Attendance by Use of a Behavioral Contract" (J. Langley); "Elimination of 'Hyperactive' Behavior in a 5-year-old Kindergarten Student" (M. Palmer); and "A Student School Contract" (M. Juskelis).

Hansell, B. et al. School psychological services and children with behavior disorders. Des Moines: Division of Pupil Personnel Services, Iowa State Department of Public Instruction, 1977.

The document provides information from the practitioner's viewpoint regarding the school psychologist's contribution in serving children with behavior problems. Many variables, such as federal and state laws, professional standards and guidelines, as well as codes of ethics and trends in psychology, are seen to effect the decision making process for the psychologist in organizing and providing appropriate service for children with behavior disorders. The authors have drawn together information on the above variables and applied it to the following topics: identification, planning, intervention strategies, and working with parents.

Harvey, V.G.S. The effect of relative age and other variables on rate of referral for school psychological services (Doctoral dissertation, Indiana University, 1979).

Hines, L.J., Jr. Youth guidance agency, its origins and development, the effectiveness of a public high school based private social service agency in treating truant, drop-out, and acting-out adolescents (Doctoral dissertation, Northwestern University, 1981).

Hinkle, K. et al. School psychological services in secondary schools. Des Moines: Division of Pupil Personnel Services, Iowa State Department of Public Instruction, 1977. (Monograph)

The monograph includes three papers on the provision of school psychological services in secondary schools. "Perspectives in Psychological Services at the Secondary School Level" (by K. Hinkle and S. Sommers) provides a state of the art review of past, present, and future trends. D. McEchron's paper, "School Psychological Services in the Secondary Schools," includes discussion of such issues as learning disabilities, mental disabilities, and crisis intervention. The final paper is titled "School Psychological Services at the Secondary Level" by D. Scarborough and reviews the author's functions as a high school psychologist in such areas as counseling, assessment, and consultation.

Janes, G. School psychological services and research in schools. Des Moines: Division of Pupil Personnel Services, Iowa State Department of Public Instruction, 1977.

The author considers the involvement of school psychologists in research projects designed to improve services and meet the educational and behavioral needs of children. Reasons why research and evaluation are important are pointed out, the kind of research needed to be done is discussed, and a brief description and schematic of a service model whereby individuals who pose practical and potentially researchable ideas and questions would be able to implement them is proposed.

Kaufman, M.J., & Kukic, M.B. An instruction-based appraisal system for the provision of psychological services. In S. Miezitis & M. Orme (Eds.), Innovation in School Psychology (No. 7, Symposium Series). Toronto: The Ontario Institute for Studies in Education, 1977.

Studies on the role of school psychologists in special education are cited to show an overemphasis on pupil eligibility concerns to the neglect of comprehensive appraisal. Reviewed are basic objectives, processes, and underlying assumptions in a comprehensive appraisal model. Among features ascribed to such a model are instruction in writing behavioral objectives, emphasis on criterion referenced measures, and communication among all involved personnel.

Kramer, J.J., & Nagle, R.J. Suggestions for the delivery of psychological services in secondary schools. Psychology in the Schools, 1980, 17(1), 53-59.

Kermes, J.J. A study of the conceptualization and utilization of psychological services by school personnel in selected school systems in Pennsylvania (Doctoral dissertation, University of Pittsburgh, 1972).

Maher, C.A. Guidelines for planning and evaluating school psychology service delivery systems. Journal of School Psychology, Fall 1979, 17(3), 203-12.

Contemporary standards of professional practice (e.g., American Psychological Association, 1977) and recent educational compliance legislation (e.g., P.L. 94-142--The Education for All Handicapped Children Act) emphasize the delivery of appropriate school psychological services geared to a range of school age children with special needs. Thus, school psychologists must pay increased attention to the development of school psychology service delivery systems. Toward this end, guidelines are presented for planning and evaluating school psychology service delivery systems. The guidelines are set forth in order that school psychologists might consider them and adapt them to local circumstances. The eight principles which comprise the guidelines have been used by the author in planning and evaluating school psychology service delivery systems in several public school districts. One particular school district illustrates the utilization of the guidelines.

Maher, C.A. A systems framework for field training in school psychological services. Professional Psychology, 1980, 11(4), 550-560.

McWhirter, J.J. The learning disabled child: A school and family concern. Champaign, Ill.: Research Press, 1977.

Intended for parents, teachers, and pupil personnel workers, the book presents educational, psychological, and professional perspectives on the learning disabled (LD) child. The section on educational perspectives covers such topics as confusions related to LD, remediation systems, and activities for dealing with visual and auditory perception problems. Psychological strategies are considered in the second section, including a communication model based on theories of C. Rogers and T. Gordon, corrective procedures of A. Adler and R. Dreikurs, and applied behavior modification principles. The role of counselors in providing guidance services to children and their families is examined in the final section.

Millard, T.L. The counselor as referral agent: Matching client problems with community agency resources. Journal of the International Association of Pupil Personnel Workers, Winter 1981, 25(1), 32-39.

School counselors often must decide if they can help a client or if they should refer him to another community agency. The counselor may act as interpreter, negotiator, advocate, advisor or educator in helping individuals who seek access to community services.

Miller, A., & Ellis, J. A behaviour management course for a group of mothers: The importance of the course setting for effective use of available resources. Child Care, Health and Development, May-June 1980, 6(3), 147-55.

Many patients experience difficulty in managing aspects of their young children's behaviour; and yet personnel with the psychological skills to resolve these problems are only available to a small proportion of parents, usually after a period of serious escalation of the difficulties. This article describes an attempt to make economical use of an educational psychologist's time by providing a short course for a volunteer group of mothers whose children attended a pre-school group. The educational orientation of the centre is shown to facilitate the transmission of the required skills and knowledge to the mothers, suggesting both a desirable form or organization for such centres and a specific activity which could profitably take place within them.

Murray, J.N., & Wallbrown, F.H. School psychological services for learning disabled students. Journal of Learning Disabilities, August-September 1981, 14(7), 385-87.

The article examines school psychological services for learning disabled students in the areas of assessment, consultation, program development, counseling, and research. The consultation role is seen to involve working with child study groups, teacher training, individual teacher consultation, encouraging affective education, being aware of legislative requirements and community resources, and disseminating information.

O'Hern, J.S.; & Nickerson, E.T. School mental health: Training for collaboration. Washington, D.C.: National Center for Improvement of Educational Systems (DHEW/OE), 1976.

The Boston University Interdisciplinary School Consultation Project was initiated in 1971 and continued until the end of the school year in 1974. Its major objectives were: (1) to improve the skill, capacity, and understanding of those who wanted to work in urban areas, and (2) to develop collaborative methods of dealing with children and families in schools and communities. The program involved graduate students from Boston University's School of Education (Counselor Education Department), School of Social Work, and School of Nursing, as well as students from the New Careers Program of Metropolitan College. Faculty members from the various schools were involved in planning, supervision and teaching the trainees. The Boston University team provided a number of traditional and innovative services to the schools in which it worked. Programs in the areas of alcohol education, career information, parent involvement, and ethnic pride were only some of the tasks undertaken. The emphasis was on collaboration among team members and with school personnel and community members. Research and evaluation efforts were on-going components of the project. A number of studies were undertaken to assess the efficacy of various programs and the composition of the client population.

Phillips, B.N. School stress and anxiety: Theory, research and intervention. New York: Human Sciences Press, 1978.

The text addresses the diagnosis, nature, and treatment of school anxiety in children. An initial chapter reviews the construct of anxiety and focuses on measurement of school anxiety by such methods as the children's school questionnaire, sociometric nominations, and standardized tests. Chapter Two analyzes the nature of stressful school situations, and points out sources of achievement and social stress. Research on anxiety in the elementary school is reported in Chapter Three, with a discussion of age, sex, and socioeconomic factors involved. Studies on the effects of schooling on anxiety, including research on school environmental factors and the affective significance of the school environment in different subcultures are reviewed in the fourth chapter. The final chapter proposes a model for school psychological services intervention to deal effectively with school stress, and considers such other intervention strategies as resocialization, crisis prevention, and psychologic inoculation.

Psychological intervention: Case studies in school psychological services (Vol. 3). Des Moines: Drake University, 1979.

The book presents 27 case studies illustrating psychological interventions with behavior problem school children. Studies usually introduce the target population, describe the method of psychological evaluation, report the results of treatment, and discuss the case's implications. Among cases reported are investigations of stimulant medication on hyperactive students, behavioral intervention for a depressed preschooler, a Gestalt approach to counseling an adolescent, the use of cognitive behavior modification, evaluation of hearing impaired students, selective mutism, relaxation training with enuretic students, chronic absenteeism, treatment of encopresis, school phobia, dropouts, and group counseling with secondary school special education students.

Ramage, J.C. Litigation and legislation effects on the school psychologists' role. *Journal of Learning Disabilities*, August-September 1981, *14*(7), 380-82.

The article focuses on how the role of school psychologists is being influenced by litigation and legislation and how school psychology is reevaluating its professional standards and ethics. Noted are requirements of P.L. 94-142 (The Education for All Handicapped Children Act) which affect psychological services in public schools.

Romig, C.W. *Attitudes of classroom teachers toward the roles of the school psychologist and other personnel of a psychological services center for children* (Doctoral dissertation, University of Northern Colorado, 1970).

Roosa, L.W. *Planning the utilization of school psychological services: A systems approach* (Doctoral dissertation, Rutgers University-New Brunswick, 1972).

Shimoni, N. *Development and evaluation of a model of school psychological services--A system approach* (Doctoral dissertation, University of North Carolina at Chapel Hill, 1972).

Siegel, D.J. Children's behavior problems and referral for school psychological services. *Psychology in the Schools*, July 1981, 18(3), 364-68.

Personality and conduct problem behaviors from Quay and Peterson's behavior problem checklist were rated by considering their significance in referring an elementary grade child for school psychological services. Spearman correlations indicated that regular class teachers, special class teachers of the emotionally disturbed, and school psychologists agreed regarding the relative importance of the behavior problems. A repeated measures analysis of variance revealed that conduct problems were prioritized by the professional groups for referral. This consistent agreement across professional groups is interpreted in terms of ecological psychology. Considering the behavioral demands of the schools, the conduct problem child achieves the poorest behavior milieu fit and is perceived as a priority for referral.

Slaughter, R.K. *Maryland public educators' perceptions of school psychological services* (Doctoral dissertation, Temple University, 1980).

Spade, L.I. *School personnel perceptions of proposed psychological services in the schools* (Doctoral dissertation, Ohio State University, 1973).

Steinberg, M.A., & Chandler, G.E. Developing coordination of services between a mental health center and a public school system. *Journal of School Psychology*, Winter 1976, *14*(4), 355-361.

This paper examines the relationship of a town-supported mental health program and the town's public school system. Highlighted are the variety of problems which develop and strategies adopted to resolve the problems.

Tomlinson, J.R., Acker, N., Canter, A., & Lindborg, S. Minority status, sex, and school psychological services. *Psychology in the Schools*, October 1977, *14*(4), 456-460.

The relationship between sex and minority status, and frequency of referral, type of problem, and nature of subsequent psychological services was investigated with 355 students referred for psychological services from urban schools. A significantly higher percentage of both minority students and males were referred. When referral problems were categorized as either academic or behavior problems, there were no differences between majority and minority students nor between males and females. Parent contacts were made significantly more often for majority students and females, and recommendations to parents of majority students were more varied than those made to parents of minority students. Special education resource services were recommended significantly more often for minority students.

Tyerman, M.J. The schools psychological service in 1980. Bulletin of the British Psychological Society, October 1981, 34, 377-380.

Ulman, J. Follow-up on psychological services: State of the art. Des Moines: Division of Pupil Personnel Services, Iowa State Department of Public Instruction, 1979.

The paper reviews follow-up school psychological services with handicapped and nonhandicapped students in terms of rationale. Research support, and a survey of its implementation by 121 school psychologists. Follow-up is defined as the continued involvement of the school psychologist following the completion of the problem identification and analysis phases with an individual child. It is explained that analysis of response patterns from the surveys indicated that 76% of the psychologists said they provide follow-up for all or most of the students receiving psychological services; 89% use an informal follow-up system, typically involving the recontact of significant individuals within the life of the child; and that annual review staffings and 3 year reevaluations were the most frequently cited formal follow-up systems.

Veatch, B.A. Historical and demographic influences in the development of a situation specific model of school psychological services (Doctoral dissertation, University of Cincinnati. 1978).

White, P.L. The effects of three consultation modes on several criteria of effective school psychological services (Doctoral dissertation, University of Kansas, 1974).

Social Services

Constable, R.T. The home and school visitor and the recidivist, nonattendant school child: The association of selected elements of a relationship with outcome of a social service in the Philadelphia public schools (Doctoral dissertation, University of Pennsylvania, 197[illegible]).

A final program report from Jane Addams School of Social Work, University of Illinois, Urbana: The School-Community-Pupil Training Program, 1971-1974. Washington, D.C.: Office of Education (DHEW), 1974.

The primary goal of the School-Community-Pupil (SCP) project at the Jane Addams School of Social Work at the University of Illinois, Urbana was to train a new kind of professional school social worker who would work to improve the way school systems respond to children, particularly minority children. The SCP project was based on the hope that with training and directed practice, the interns could be of help to the school districts in which they worked at the same time that they were learning about school social work. To this end, evaluative information kept project faculty informed of program strengths and weaknesses and encouraged revision of course content and internship plans as needed. The academic courses emphasized planned change in institutions. Instructors prepared students to identify school situations which were, or might become, problem situations for children, such as desegregation, ability grouping, and antisocial behavior. Working with the school administrators, field supervisors, and social workers, the student interns applied problem-solving techniques learned in class to actual school situations. With administrative sanction, then, student interns were encouraged to contact teachers, pupils, psychologists, and parents in their efforts to alleviate problem areas. Over an experimental period of three years, the SCP model was practiced by 52 interns in school systems in Illinois. The results of the program evaluation indicate that the SCP approach to school social work should be continued.

Gueringer, G.E. School social work services in the New Orleans public schools. Journal of the International Association of Pupil Personnel Workers, June 1979, 23(3), 168-70.

This article concerns itself with an overview of school social services in the New Orleans public school system. It deals with historical review; meaning and definition of school social services; who is best qualified to administer the service; a case example demonstrating social work intervention; and other professional social services.

Hoops, R.C. The coordination of social services between public schools and municipal government agencies (Doctoral dissertation, Rutgers University-New Brunswick, 1964).

Meares, P.A. The impact of Public Law 92-318. Social Work in Education, October 1979, 2(1), 18-27.

The article describes the provisions of Public Law 92-318 (The Emergency School Aid Act) with emphasis on its implications for school social work methods and tasks. The intent of the law is to provide financial assistance for the elimination of minority group segregation and discrimination practices in the schools through such activities as special remedial services, hiring and training of teacher aides, and inservice teacher training. Five different models of providing school social services under the law are compared: traditional casework or direct services; the school-change model; the community-school model; the social interaction model; and the school-community-pupil model. The author recommends that the National Association of Social Workers lead the profession in emphasizing understanding of educational legislation.

NASW Standards for Social Work Services in Schools (Policy Statement No. 7). Washington, D.C.: National Association of Social Workers, 1978.

The National Association of Social Workers (NASW), as the collective expression of some 78,000 professional social workers, is responsible for practice advancement, standards-setting and utilization, and the improvement of social service policies and programs. The development of standards for social work services in schools is one significant component of the spectrum of activities to advance the mission of education through social work services. These standards are the product of several years of investigation and direct involvement of school social work practitioners, social work consultants in state departments of education and social work educators. Organized into three sections, the standards delineate: (1) the values, knowledge and skill that form the competence for school social work practice; (2) the social work profession's expectations of the administrative environment of the school; and (3) the professional responsibility of the school social worker. The next objective for the social work profession is to obtain the full acceptance and implementation of the standards in all school systems of the 50 states.

Roten, S.J. Comprehensive social service programs for handicapped citizens through Title XX. Paper presented at the 55th Annual International Convention of the Council for Exceptional Children, Atlanta, Georgia, April 11-15, 1977.

Reviewed are present and potential services and social programs for handicapped children in Mississippi through purchase of service contracts under Title XX of the Social Security Act. Sections cover the following topics: background and purpose of Title XX which gives states greater control over Social Security programs, planning state supported and private programs for the handicapped, types of social services provided (which include day care for handicapped children and adults, diagnostic and evaluation services, and counseling for self care), monitoring and evaluation of programs, gaps in service provision (such as the need to include more fee paying clients), and problems for the future (such as lack of adequate funding).

Schafler, M. Individualized educational programs in a school for the handicapped. Social Work in Education, October 1980, 3(1), 32-43.

A social worker in a school for severely handicapped children uses four case examples to demonstrate how the preparation of individualized education programs (IEPs) has helped alleviate family difficulties that hampered students' educational achievements. School social services are seen to be an important part of IEP development and parent-school relationships.

Sedlak, M.W. The origins and evolution of social work in the schools, 1906-1970. Paper presented at the 65th Annual Meeting of the American Educational Research Association, Los Angeles, April 13-17, 1981.

The years between 1900 and 1920 marked the formative era in the history of school social work. Social work programs were introduced into the schools by private organizations and community groups and were formed to prevent truancy and delinquency, to rehabilitate poor families through relief services, and to "Americanize" the foreign-born populations. Visiting teachers hired to staff these programs focused on environmental conditions rather than on the individual child. After World War I, a period of intense professionalization in school social work began, lasting from 1920 until 1965. Significant forces affecting school social work during the 1920s were the formation of the Commonwealth Fund of New York City and the mental hygiene movement. The expansion of federal relief and welfare programs after the Depression allowed professional social workers to refocus efforts on case work and individual therapy; only after World War II did the services of social workers and counselors again flourish in the schools. In the era of federal intervention (1965-1972), local schools purchased social services from private agencies suggesting that, although schools had "housed" social service programs, such programs were never fully absorbed by the schools.

EVALUATION/MONITORING

Armer, B., & Thomas, B.K. Attitudes toward interdisciplinary collaboration in pupil personnel services teams. Journal of School Psychology, Summer 1978, 16(2), 167-76.

A scale designed to measure the extent of collaboration of pupil personnel services teams was validated against a judge's rating of collaboration and the existence of regular planning meetings between pupil personnel services teams and school personnel.

Colligan, R.C., & McColgan, E.B. Perception of case conduct as a means of evaluating school psychological services. Professional Psychology, 1980, 11(2), 291-297.

Fairchild, T.N. Stepps: A model for the valuation of school psychological services. School Psychology Review, Summer 1980, 9(3), 252-58.

Evaluation should be an integral part of the services provided by school psychologists to assure that exceptional children are receiving appropriate services, and in order to ascertain the efficacy of school psychological services. In order to assist school psychologists in their evaluative endeavors, the Stepps model is presented. The Stepps model, a systematic, total evaluative process for psychological services, is outlined for practitioners to use as a framework when conducting school-based evaluations. Various considerations that affect evaluation manageability are discussed, and the model's applicability is highlighted through the presentation of a practical example. Stepps is a generic model that is applicable to a wide range of evaluation concerns. Although the emphasis is upon comprehension evaluation of all services, the model allows for less comprehensive evaluation efforts while the practitioner develops evaluation skills and before enlarging the scope of the evaluation.

Footman, G.E. et al. Pupil personnel services guidelines for program evaluation. Troy, N.Y.: National Association of Pupil Personnel Administrators, 1977. (Monograph)

This monograph attempts to approach educational program evaluation from a total program approach rather than from the level of student achievement. Although intended for use in pupil personnel areas, it also has applicability in other areas. It begins with definitions of program evaluation, including formative and summative evaluation. The step-by-step procedure for conducting an educational needs assessment is explained. One chapter deals with establishing performance objectives. Planning the evaluation program and monitoring progress are explained. Steps for collecting data for a formative evaluation are outlined as are steps and instrumentation for conducting a summative evaluation.

Guide for evaluation of special education programs and related pupil personnel services. Trenton, N.J.: New Jersey State Department of Education, 1979.

Two purposes are served by this guide: to allow school districts to examine their special education programs and related pupil personnel services; and to aid state departments of education in evaluating the nature, scope, and quality of school district offerings to handicapped students. The guide is divided into two parts: one provides forms for tabulating data and the other consists of chapters, each dealing with a specific component to be assessed. Criteria, derived from federal and state legislation and regulations and professional practices, are listed for evaluating each component. Questions are also provided to assist in examining the significance of the collected data and to understand the implications for corrective action. The components to be evaluated are: the annual plan for special education and related services; identification, screening, and referral; evaluation and classification; individualized educational programs; special education programs and related services; program administration; pupil personnel services; staff development, orientation, and training; pupil records; transportation; physical facilities; finance and budget; services to pupils in private schools; and community and interagency relations. A number of checklists are included.

Howe, C.E., & Fitzgerald, M.E. Evaluating special education programs. *Focus on Exceptional Children*, February 1977, *9*, 1-11.

Outlined is a model based on work prepared for the area education agencies (AEA) of the Iowa Department of Education for evaluating effectiveness of special education programs. Described are three levels of evaluation: Level I, which involves the use of opinionnaires and structured interviews to obtain views of directors, assistant directors, and coordinators regarding programs and services for the handicapped, in general; Level II, focusing on opinions of middle management AEA personnel (such as supervisors, consultants, and program heads) regarding specific programs, such as resource rooms, psychological services, and audiology; and Level III, which consists of child change data gathered through such techniques as goal attainment scaling.

Lindsay, G. An evaluation of a school psychological service--the Portsmouth pattern. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 1981, *22*(4), 426-427.

Maher, C.A., & Barbrack, C.R. An approach to goal-based evaluation of school psychological service departments. Psychology in the Schools, 1981, 18(3), 309-315.

Payne, T.A.N. Evaluation of a school psychological service. Bulletin of the British Psychological Society, May 1979, 32, 206.

Title III ESEA: Supplementary educational centers and services and guidance, counseling, and testing; project evaluation reports, FY 74. Cheyenne, Wyom.: Wyoming State Department of Education, 1974.

This state of Wyoming evaluation report on programs, projects, services, and activities funded in whole or in part under Elementary Secondary Education Act Title III, is divided into two parts. Part 1 includes summaries of the implications and recommendations drawn from on-site visits to each of the projects, including such projects as Personalizing Learning Opportunities, Making Use of Sight and Ear, Continuous Individualized Learning K-12, Sharing Hastens a Realistic Education, Shaping and Sharing Human Values, Development of a Physical Therapy Program for Treatment of Specific Learning Disabilities, Occupational Education in the Classroom, and 18 other projects. Part 2 consists of the rationale and forms typically used on an on-site visit.